Tel: (801) 317-4757
Fax: (801) 605-3439
1920 W 250 N, #24
Ogden, UT 84404
admin@advanced-injury-rehab.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Last Name: ____

Sex: M / F

First Name: ____

Marital Status: M S W D

Street: ____

Pregnant? Y N **No. of Children:** ______________

City: ____

Drivers License #: __________________________________

Zip Code: ______________________ **State:** _________________

DOB: ____

Home Phone: ____

Employer: ____

Work Phone: ____

Employer Name & Address: __________________________

____

Cell Phone: ____

Email: ____

Spouse/guardian name: _____________________________

SS#: ____

Spouse's Occupation/Employer: ______________________

Do you have insurance that covers chiropractic? Y N
If so, please provide receptionist with a copy of your card.

How do you intend to pay for today's visit? _____________

What is the best time and manner to contact you? ____

Who may we thank for referring you? ____

When was your last chiropractic adjustment? ____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns According to their severity	Rate severity 1 = mild 10 = worst	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time the pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate / shoot anywhere? If so, where? ______________________________________

____

Since the problem(s) started is it: **About the same?** ☐ **Getting better?** ☐ **Getting worse?** ☐

What have you done for this condition? Was it of benefit? ____

____

I do (do not) have a family history of this or similar symptoms (Please explain): _____________________________

____

____

Which activities aggravate your condition? ____

____

Other doctors you have seen for this condition:

“Limited Scope” Chiropractor (focuses mainly on neck and back pain)	**Y N**
“Wellness” Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	**Y N**
Medical Doctor	**Y N**
Other (please describe)	**Y N**

Doctor’s details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been “forced” or “felt the need” to make any “positive” changes in your life due to this pain, illness, condition, etc? (i.e. eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

____

____

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History

Often times, accumulation of life’s stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-ray taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

____

____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

____

____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If dietary changes are indicated, would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
Would you take whole food supplements if indicated?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help, would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would help you, would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D – Consume this **daily** **W** – Consume this **weekly**
M – Consume this **monthly** **O** – Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet Food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables		Microwave Popcorn	Peanut Butter

Past Health History

Please mark the following conditions you may have had or have now (**-** have had, **+** have now).

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ High Blood Pressure
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Asthma	☐ Morning Stiffness
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Depression
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ Migraines	☐ Gall Bladder Prob's
☐ Irregular Periods	☐ Low Blood Sugar	☐ Acid Reflux	☐ Crave Salt	☐ HIV (Aids)	☐ Sinus Problems
☐ Miscarriage	☐ Multiple Sclerosis	☐ Fatigue	☐ Neck Pain	☐ Neuritis	☐ Whooping Cough
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Bruising Easily	☐ Nervousness	☐ Ringing in Ears
☐ Stroke	☐ Thyroid Problems	☐ Dizzy rising up	☐ Ulcers	☐ Crave Sugar	☐ Menstrual Cramps

Stressors

Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. ____
   b. ____
   c. ____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. ____
   b. ____
   c. ____
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. ____
   b. ____
   c. ____

On a scale of 1-10, please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else which may help us to better understand your issues, which has not been discussed?

____
____
____
____

Why are you here at this point in time?

____
____
____
____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

Patient Name (Print): ______________________________________

Patient Signature: ______________________________________ Date: ____________________

Parent/Guardian Signature: ________________________________ Date: ____________________

HIPPA / Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Use and disclosure of protected information

Your health information will only be used by the doctor, our office staff and others outside of our office that are involved in your case of treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Health Operations

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings; Law Enforcement, Coroners, Funeral Directors and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker’s Compensation; Inmates. Under the law we must make disclosures to you and when required by the Secretary of the department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Your Rights

You have the right to inspect and copy your protected health information other than psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

____
Patient Name (Print)

____ ____
Patient Signature Date

◄ PATIENT AGREEMENTS ►

In consideration of treatment by the doctor the undersigned agrees as follows:

1. To pay the amount charged by the doctor for all professional treatment and services to the undersigned and/or his/her family. Payment to be made to Advanced Injury Rehabilitation, LLC.

2. All charges are due and payable at the time of service unless other financial agreements are made.

3. Any balance due 30 days after treatment will be subject to a 2% per month service charge (APR of 24%).

4. To pay all collection fees, settlement fees, reasonable attorney fees, and costs incurred in the event of referral to any collection agency, arbitration / mediation process, or suit. I further agree to pay all fees for collections, including a 40% agency commission fee.

5. That in the event of death, this obligation shall be binding on the estate, heirs or successors of the undersigned.

◄ FINANCIAL ARRANGEMENTS ►

1. This office will accept payment for services by cash or all major credit cards.

2. This office has several types of financial plans available. A Chiropractic Assistant will discuss this with you upon request. Any alteration to our regular fees must be set to paper and signed by both parties to be binding.

3. I clearly understand and agree that I am responsible for the payment of all services rendered to me. I also understand that if I terminate care, any professional fees for services will become due and payable.

◄ CHIROPRACTIC INSURANCE ►

1. If you have medical insurance that covers chiropractic, your estimated portion is due and payable at the time of service. If after this office receives payment from the insurance company, and a balance remains, a statement will be sent to you.

2. If an insurance payment is not received within 60 days, the full amount is due and payable by you.

3. The filing of a secondary insurance is your responsibility.

I do herby agree to the above arrangements. I give permission for the doctor and/or his designated employees to perform chiropractic services for myself. If services are for a minor I am responsible for, the name of such minor will be listed below as the patient.

____
Patient Name (Print)

____ ____
Patient Signature (Parent or Guardian) Date