TAKAHASHI CHIROPRACTIC

PATIENT HISTORY

DATE: _____

Name: _____ Phone: (cell)_____

Email:_____ Phone: (Other)_____

Address: _____ City: _____

State: _____ Zip:_____ Date of birth: _____/_____/_____ Age: _____

Married: _____ Single: _____ Occupation: _____ Employer:_____

Work Address: _____

INSURANCE: (Be sure to provide a copy of insurance card to front desk staff)

Insurance Name: _____ Policy #: _____

Primary Holder Name: _____ Primary D.O.B: ____/____/_____

Do you have an open legal claim such as a car accident or work injury case? YES NO

List your complaints in order of severity:

1. _____ How long?_____

2. _____ How long?_____

3. _____ How long?_____

Have you been involved in or have ANY of the following:

____ Car Accident *Date of accident ____ / ____ / ____

____ Work Related Accident/Injury *Date of accident ____ / ____ / ____

____ Sport Injury or Trauma *Date of injury ____ / ____ / ____

____ Chronic Condition: Diabetes, Arthritis, Heart Condition, Liver Condition

____ Other Medical Condition(s): _____

Have you had chiropractic Care before? YES NO

Have you consulted other Doctors for this condition? YES NO

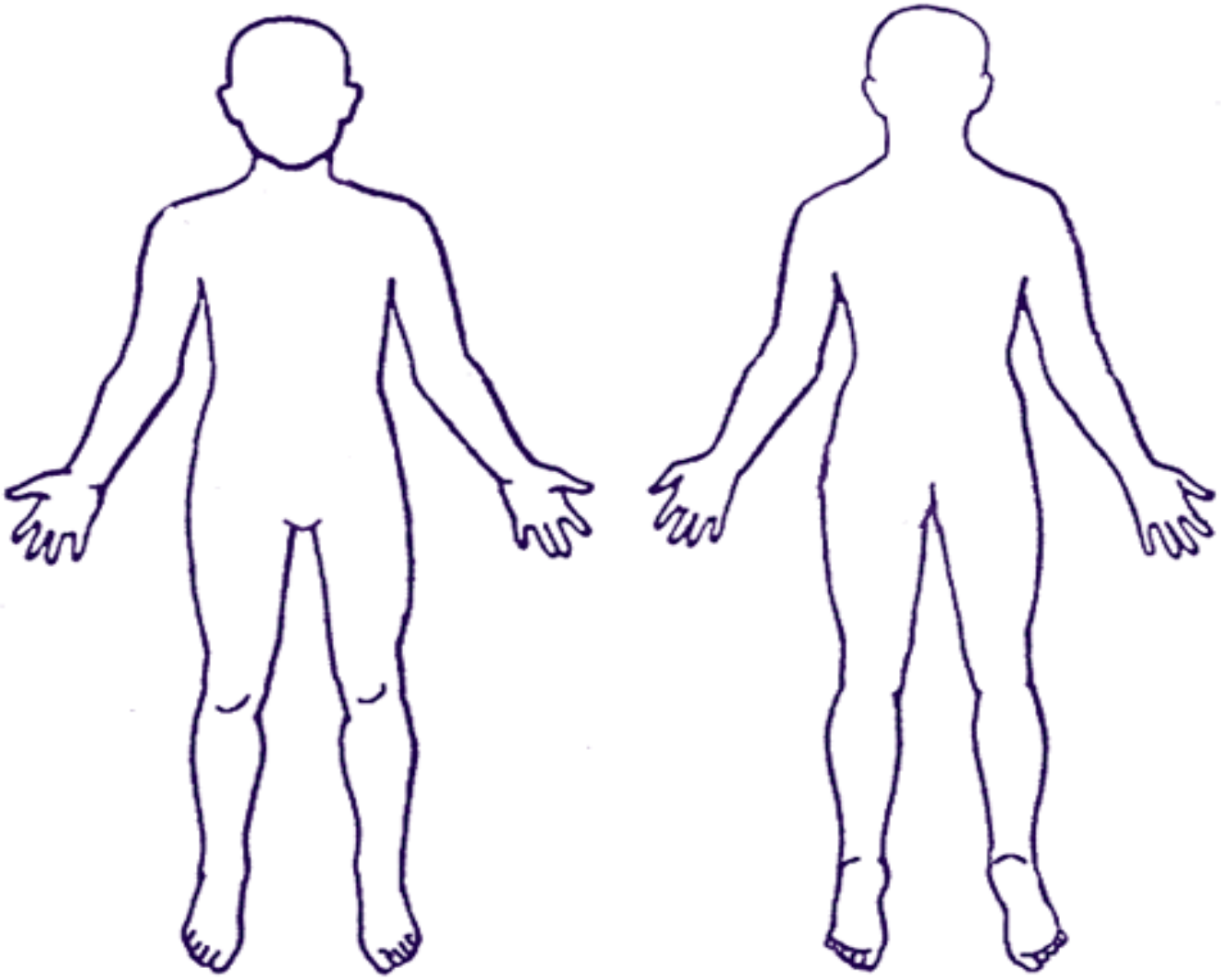
Who? _____ _____ _____

How were you referred you to our office? _____

VISUAL ANALOG SCALE

Please mark the areas of discomfort or concern:

Front Back



LEVEL OF SYMPTOM SEVERITY

___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

(0 = NO SYMPTOMS) (10 = SEVERE SYMPTOMS)

Comments:_____

_____

_____

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PERSONAL MEDICAL INFORMATION CONSENT FORM

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

This consent gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or part of health care operations of our practice. HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke this consent in writing. Though any services performed prior to the revocation of this consent are covered by this consent.

PATIENT OR PARENT/GUARDIAN SIGNATURE

_____ **DATE: _____**

RESTRICTIONS:_____
_____
_____
_____
_____

OUR RIGHTS

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices my be required by change in federal and state law regulation. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practice will be applied to all protected health information we maintain.

Doctor / Staff Signature:_____ Date:_____