Patient Information Form

First Name: _____ **MI**_____ **Last Name**_____

Date of Birth: _____ **Gender: Male**___ **Female**___ **SSN:** _____

Mailing Address / P.O. Box: _____**City:** _____**State:** _____ **Zip:** _____

Mobile Ph:_____ **Texting? Yes No Email:** _____ **Marital Status: S M D W**

Occupation:_____ **Employer:** _____

Emergency Contact: _____ **Phone Number:** _____ **Relationship:**_____

Updated Patient Information

Preferred Language: ☐English ☐Spanish ☐Other_____

Race: ☐I do not wish to provide this information
☐White
☐Black or African American
☐American Indian or Alaska Native
☐Asian
☐Native Hawaiian or other Pacific Islander
☐Other _____

Ethnicity: ☐I do not wish to provide this information
☐Hispanic or Latino
☐Non-Hispanic or Non-Latino
☐Other_____

Smoking Status: ☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Never smoker

Do you have any medication allergies? ☐ No known medication allergies
☐ Yes. What_____

Are you currently taking any medications? ☐Not currently prescribed any medications
☐ Yes. What? _____ _____mg or mcg _____ _____mg or mcg

_____ _____mg or mcg _____ _____mg or mcg

Name of last Chiropractor: _____

Name of Primary Care Provider:_____

How did you hear about our office?

_____**Internet** _____ **Newspaper** _____ **Radio** _____ **Personal Referral:** Whom may we thank? _____

☐ **Work Injury** ☐ **Auto Accident** ☐ **Other Accident**

I understand that (regardless of my insurance status) I am ultimately responsible for this balance on my account for all professional services rendered. **I understand that I am responsible to determine my insurance benefits.**
I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____
Signature Date

If Patient is a minor
Parents/Guardian Name: _____

Age_____

Office Use Only-PLEASE DO NOT FILL OUT

Vital Signs: BP_____/_____ L/R Supine Seated Standing
Height_____ **Weight**_____ **Pulse**_____ **Resp**_____ **Temp**_____
Dynanometer (Kgs): R_____/_____/_____ **L**_____/_____/_____

Brookings Chiropractic Center
Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations, **we must require you to read and sign this consent form** stating you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Brookings Chiropractic Center to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, research and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient at Brookings Chiropractic Center. The patient also understands that 50 years following their death, authorization is not required to disclose private health information.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff within the facility has been trained in the area of patient records privacy and a privacy official have been designated to enforce those procedures. Common storage of all PHI for the Brookings Chiropractic Center provides one secure location within the facility. We have taken all precautions known by this office to assure your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient/Parent/Guardian Signature Date

I, _____, authorize Brookings Chiropractic Center to discuss my condition and account information with any of the following person or persons list below.

_____, _____, _____

_____

Patient/Parent/Guardian Signature Date

Patient History

Name: _____ Date:_____

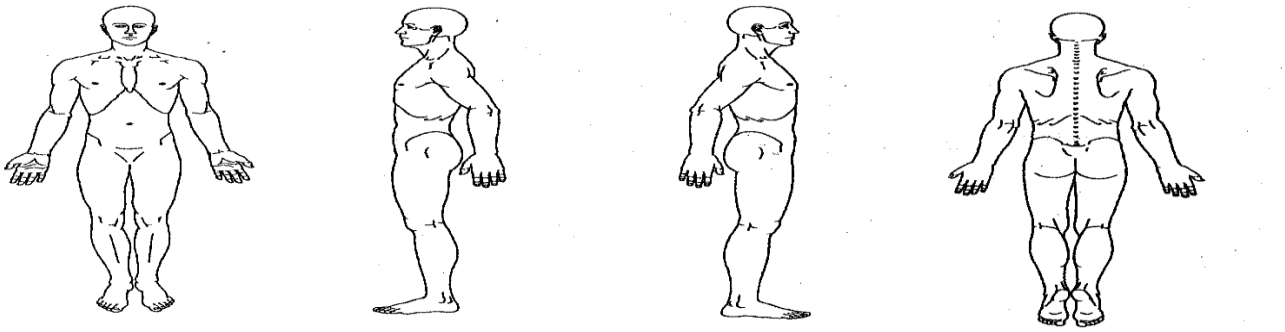
What brings you into the office today?_____

_____

Please answer the following questions as completely as possible:

Where is your pain? _____

Draw on the diagrams below indicating where you have pain.



When did it start?

_____

How did it happen?

_____

This complaint came on: ☐ Gradually ☐ Immediately
This complaint is: ☐ Improving ☐ Staying the same ☐ Getting worse
The intensity of this complaint is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe
The frequency of this complaint is: ☐ Occasional ☐ Frequent ☐ Constant
The pain is: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing ☐ Burning ☐ Tingling

Have you seen another doctor for this problem? __ yes __ no Whom? _____
Have you had any diagnostic tests (x-ray, lab, MRI, etc.) for this condition? _____

_____

Have you had any of the following disease/medical condition(s)?

Y N Heart Attack/Stroke
Y N Congenital Heart defect
Y N Alcohol/Drug Abuse
Y N HIV+/AIDS
Y N Frequent Neck Pain
Y N High/Low Blood Pressure
Y N Severe/Frequent Headaches
Y N Fainting/Seizures/Epilepsy
Y N Diabetes/Tuberculosis
Y N Lower Back Problems
Y N Heart Surg./Pacemaker
Y N Mitral Valve Prolapse
Y N Venereal Disease
Y N Shingles
Y N Emphysema/Glaucoma
Y N Psychiatric Problems
Y N Kidney Problems
Y N Sinus Problems
Y N Difficulty Breathing
Y N Artificial Bones/Joints
Y N Heart Murmur
Y N Artificial Valves
Y N Hepatitis
Y N Cancer
Y N Anemia
Y N Rheumatic Fever
Y N Ulcers/Colitis
Y N Asthma
Y N Chemotherapy
Y N Arthritis

	The following are activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	**Yes, Limited A lot**	**Yes, Limited a Little**	**No, Not Limited**
1	Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports			
2	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
3	Lifting or carrying groceries			
4	Climbing several flights of stairs			
5	Climbing one flight of stairs			
6	Bending, kneeling, or stooping			
7	Walking more than a mile			
8	Walking several blocks			
9	Walking one block			
10	Bathing or dressing yourself			

Please rate your pain from 0 to 10 (10 being the highest possible level of pain) for <u>ONLY</u> the areas of concern.

	LEVEL OF PAIN										
Overall Condition	0	1	2	3	4	5	6	7	8	9	10
Headache	0	1	2	3	4	5	6	7	8	9	10
TMJ	0	1	2	3	4	5	6	7	8	9	10
Chest	0	1	2	3	4	5	6	7	8	9	10
Abdomen	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Mid back	0	1	2	3	4	5	6	7	8	9	10
Low back	0	1	2	3	4	5	6	7	8	9	10

<u>UPPER EXTREMITIES</u>

	LEFT											RIGHT										
Shoulders	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Arms	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Elbows	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Forearms	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Wrists	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Hands	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Fingers	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

<u>LOWER EXTREMITIES</u>

	LEFT											RIGHT										
Hip	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Thighs	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Knees	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Shins	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Ankles	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Feet	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Toes	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

BROOKINGS
CHIROPRACTIC
CENTER
& PHYSICAL THERAPY

Patient Rights & Responsibilities Policy

CONFIDENTIALITY

It is the policy of Brookings Chiropractic Center, to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please ask a front desk representative for information. Brookings Chiropractic Center makes every effort to provide our patients with an environment, which is safe, private and respectful of our patient's needs. If you have a complaint about our services, facilities or staff, we want to hear from you. We will do everything we can to see that your experience with us is professional in every way.

ISSUES OF CARE

Brookings Chiropractic Center is committed to patient participation in care decisions. As a patient, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask.

Patient Rights & Responsibilities

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know that rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to pain relief.
- A patient has the right to not share their information.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding and violation of his or her rights, as stated in South Dakota law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate licensing agency.

PATIENT RESPONSIBILITIES

- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

I have read and understand my rights and responsibilities as a patient as noted above.

_____ _____

Patient Signature **Date**