Welcome to Our Office!

Patient Data **Date**

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Date of Birth: _____/_____/_____ Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Other

E-mail Address: _____

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Occupation: _____ Is it okay to call you at work? ☐Yes ☐ No

Insurance Data

Are you the primary policy holder for your health insurance (if applicable)? ☐Yes ☐ No

Insured's Name _____ Insured's Date of Birth _____/_____/_____

Insured's Employer _____

Spouse Data

First Name: _____ Middle Initial: _____ Last Name: _____

Phone: (____)____-_____ Spouse's Date of Birth ___/___/_____

Emergency Contact

Contact Name: _____ Contact Phone: (_____) _____-_____

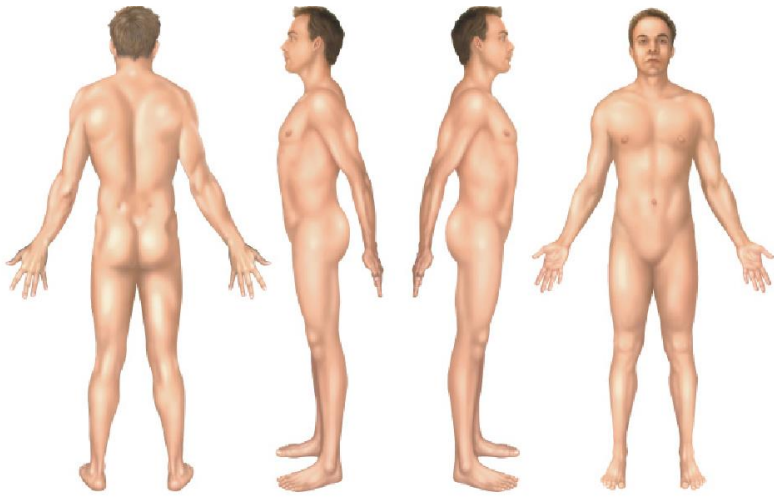
How did you hear about our clinic? Or who referred you?

- ❑ Word of Mouth
- ❑ Sign on building
- ❑ Web site
- ❑ Medical referral
- ❑ Community group
- ❑ Newspaper ad
- ❑ Yellow Pages
- ❑ Other:

If you selected 'Word of Mouth,' who may we thank for referring you? _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness X = Burning / = Stabbing
0 = Pins & Needles + = Dull Ache



Please describe your symptoms:

_____

_____

When did your symptoms start? (approximately)

_____

How did your symptoms begin?

_____

_____

How often do you experience your symptoms?			
❑ Constantly (76-100% of the day)	❑ Frequently (51-75% of the day)	❑ Occasionally (26-50% of the day)	❑ Intermittently (0-25% of the day)
What describes the nature of your symptoms?			
❑ Sharp	❑ Dull ache	❑ Numb	❑ Shooting
❑ Burning	❑ Tingling	❑ Stabbing	
How are your symptoms changing?			
❑ Getting better	❑ Not changing	❑ Getting worse	
Indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)			
❑ 0 None	❑ 1	❑ 2	❑ 3
❑ 4	❑ 5	❑ 6	❑ 7
❑ 8	❑ 9	❑ 10 Unbearable	
How much has pain interfered with your normal work or daily routine?			
❑ Not at all	❑ A little bit	❑ Moderately	❑ Quite a bit
❑ Extremely			
How much of the time has your condition interfered with your social activities?			
❑ None of the time	❑ A little of the time	❑ Some of the time	❑ Most of the time
❑ All of the time			
In general, would you say your overall health right now is….			
❑ Excellent	❑ Very good	❑ Good	❑ Fair
❑ Poor			
Have you had similar symptoms in the past? Yes No			
What treatment did you receive for your symptoms?			
❑ Adjustments	❑ Physical Therapy	❑ Medication	❑ Surgery
❑ Other:			
When did you receive this treatment?			
❑ In the last month	❑ 2 – 3 months ago	❑ 3 – 6 months ago	❑ 6 months to 1 year ago
❑ 1 – 2 years ago	❑ 2 – 5 years ago	❑ 5 – 10 years ago	
What tests have you previously had for your symptoms?			
❑ X-rays	❑ MRI	❑ CT Scan	❑ Other

Patient Signature _____ **Date** _____

Consent to Treat a Child (under the age of 18): I hereby authorize this office to administer chiropractic care to my child, _____.

Signature _____ **Date** _____
(Parent/Legal Guardian)

Health History and Lifestyle

Condition	Present	Past		Present	Past		Present	Past
Alcoholism			Eczema			Multiple Sclerosis		
Allergies			Emphysema			Numbness in Arms or Legs		
Anemia			Gallbladder			Pneumonia		
Anxiety/Nervousness			Gout			Pacemaker		
Arthritis			HIV/AIDS			**Pregnant at this time**		
Asthma			Headaches			Prostate		
Blood in Urine			Hearing Loss			Psoriasis		
Blurred Vision			Heart Disease			Rheumatic Fever		
Broken Bones			Hepatitis			Seizures		
Cancer			High Blood Pressure			Shingles		
Chest Pain			High Stress			Shortness of Breath		
Constipation			Irregular Period			Sinus Problems		
Cough/Wheezing			Jaw/TMJ Pain			Spine Curvature/Scoliosis		
Depression			Low Blood Sugar			Stroke		
Diabetes			Menopausal			Thyroid		
Diarrhea			Menstrual Cramps			Ulcers		
Dizziness			Migraines			Vascular Disease		
Easy Bruising			Miscarriage			Other (please indicate)		

If Checked, Please Explain _____

Family Medical Doctor _____ **Date of Last Visit** _____

Previous chiropractic care? _____ **Dr.** _____ **Last Visit**_____ **X-Rays?** _____

Surgeries:			
Type:	When:	Doctor:	
Type:	When:	Doctor:	
Injuries/Accidents:			
Type:	When:	Hospitalized: ❑ Yes ❑ No	
Type:	When:	Hospitalized: ❑ Yes ❑ No	
Medications/Supplements:			
Please List:			
Social History:			
❑ Caffeine used occasionally	❑ Drink alcohol occasionally	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Caffeine used often	❑ Drink alcohol often	❑ Exercise not at all	❑ Don't smoke
❑ Experience stress occasionally	❑ Wear seat belts usually	❑ Exercise occasionally	❑ Smoke 1 pack or less per day
❑ Experience stress often	❑ Wear seat belts always	❑ Exercise regularly	❑ Smoke 1+ packs per day
Family History:			
❑ Arthritis (parent)	❑ Cancer (parent)	❑ Arthritis (sibling)	❑ Cancer (sibling)
❑ Cholesterol (parent)	❑ Diabetes (parent)	❑ Cholesterol (sibling)	❑ Diabetes (sibling)
❑ Heart problems (parent)	❑ High blood pressure (parent)	❑ Heart problems (sibling)	❑ High blood pressure (sibling)
❑ Thyroid (parent)	❑ Stroke (parent)	❑ Thyroid (sibling)	❑ Stroke (sibling)
Children:			
Names & Ages:			
Occupational Activities:			
❑ Administration	❑ Business owner	❑ Clerical/secretarial	❑ Computer user
❑ Construction	❑ Daycare/childcare	❑ Executive/legal	❑ Food service industry
❑ Health care	❑ Heavy equipment operator	❑ Manufacturing	❑ Home services
❑ Household	❑ Light manual labor	❑ Medium manual labor	❑ Heavy manual labor
Recreational Activities:			
❑ Backpacking	❑ Biking	❑ Basketball	❑ Football
❑ Golf	❑ Racquetball	❑ Running	❑ Skiing
❑ Soccer	❑ Swimming	❑ Tennis	❑ Walking

Thank you for your input! Please let the office staff know that you are ready to continue.

Fitzpatrick Family Chiropractic
Notice of Privacy Practices Summary

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

In the course of your care as a patient at Fitzpatrick Family Chiropractic, we may use or disclose personal and health-related information about you in the following ways:

- It may be used as a means of communication among health care professionals who contribute to your care for further diagnosis and treatment.
- It may be used to obtain payment from a third party, such as an insurance company or Medicare.
- It may be used as a means to contact you regarding appointment reminders, missed appointments or information about alternatives to your present care or other health related information that may be of interest to you.

The physical record of your health is the property of the healthcare provider, or the facility that compiled it. However, the underlying information belongs or is available to you. You have the ability to:

- Inspect, correct, and obtain a copy of your health record, including electronic versions.
- Revoke your authorization to use and disclose health information except to the extent that action has already been taken. This will not affect the care provided to you or the reimbursement avenues associated with your care. If services are paid out-of-pocket in full, you may resist your information from shared to your insurer.
- Request communications of your health information by alternative means or at alternative locations if we are providing health care to you based on orders provided by other health professionals. Any use of your health information will only be disclosed upon your written authorization. Information that we use or disclose based on this privacy may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected in the federal privacy rules.
- Opt out of any fundraising communication and authorize any third part marketing communication.
- Obtain a copy of the Notice of Privacy Practices upon request at the front desk at this practice.

Our responsibilities at Fitzpatrick Family Chiropractic are to:

- Maintain the privacy of your health and billing information.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Contact you with there is a breach in your protected health information.
- Abide by the terms of our Notice of Privacy Practices policies.

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. “Open adjusting” involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, and presenting reports of findings. These procedures are completed in a private, confidential setting.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an “open adjusting” environment, other arrangements will be made for you. Your decision will have no adverse effect on your care at Fitzpatrick Family Chiropractic or your relationship with our staff.

If you have a complaint or would like additional information regarding our privacy policies and practices, please contact:

Dr. Brian Fitzpatrick
Fitzpatrick Family Chiropractic
101 Windflower Lane - Suite 800
Solon, IA 52333
319-624-5145
www.fitzpatrickfamilychiro.com

US Department of Health and Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
877-696-6775

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient Representative Date