Confidential Patient History

*Please use the **tab** button to move to the next field and please fill out completely*

Name____M.I._____ Date:______/______/_____________

Address ____ City_________________State______ Zip____________

Date of Birth____/____/_______ Age____ Email____

Home Telephone______/______/__________ Cell ______/______/_________

History of Chief Complaint

Where is your major area of pain or concern?____

When did you first notice it?____

What brought it on? ____

What aggravates it? ____

What relieves it? Medication___________________ Other____

Is this condition getting worse? Yes No Does it interfere with: work sleep recreation daily routine

Is this injury / condition related to or take place at: Work Motor Vehicle Collision Date: ____/____/________

Past Medical History / Review of Systems

- ❑ Headaches
- ❑ Heart Disease
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Shortness of breath
- ❑ Diabetes: ☐ NIDDM ☐ IDDM
- ❑ Frequent / Difficult urination
- ❑ Lung Disease
- ❑ Cough
- ❑ Kidney Disease
- ❑ Gastrointestinal Disease
- ❑ Liver Disease
- ❑ Urinary Disease
- ❑ Pain or burning w/urination
- ❑ Neurological Disease
- ❑ Cancer
- ❑ Alcoholism
- ❑ Thyroid Disease
- ❑ Asthma
- ❑ Skin disorders
- ❑ Fatigue
- ❑ Weight gain / loss
- ❑ Night sweats
- ❑ Dizziness ☐ Loss of balance
- ❑ Ringing in ears
- ❑ Blurry vision
- ❑ Sinus pain or congestion
- ❑ Abdominal pain
- ❑ Indigestion
- ❑ Change in bowel or bladder habits
- ❑ Anemia
- ❑ Nervousness
- ❑ Pains in arms or legs
- ❑ Numbness in hands / feet
- ❑ Painful / Stiff / Swollen joints
- ❑ Sciatica
- ❑ Arthritis
- ❑ Herniated or bulging disk
- ❑ Muscle spasms

Preventative Screenings / Family History

Males

- ❑ Prostate Disease
- ❑ Pain in groin region

Females

Are you pregnant? Yes No

- ❑ Abdominal or pelvic pain
- ❑ I visit my Female Dr. regularly

Preventative Screenings: Have you ever had

- ❑ Mammogram
- ❑ Pneumonia Vaccine
- ❑ Colonoscopy
- ❑ Flu Shot Vaccination

Family History

- ❑ Heart Disease: Who________________________
- ❑ Diabetes: Who____________________________
- ❑ Cancer: Who_____________________________

Medications

1. ___________________________
2. ___________________________

Previous Hospitalization / Operations / Injuries

1. _________________________Date___/___/___
2. Motor Vehicle Collision Injuries: Date(s):______________________________

Daily Habits: Heavy, Mod, Light, None

- ❑ **Alcohol** H M L N
- ❑ **Smoke tobacco** H M L N

Allergies:________________________

IMPORTANT PATIENT INFORMATION

I certify that the above information is complete and accurate to the best of my knowledge. I authorize Mark J. Mckim, D.C. or Melissa R. Kowasz-Mckim, D.C. (or whomever he/she designates as his assistants) to treat my condition as Dr. Mckim or Dr. Kowasz-Mckim deems appropriate, after the treatment plan is explained to me. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, verification of my insurance benefits is done as a courtesy to me, and the information obtained is not a guarantee of my health benefits, and that some insurance companies arbitrarily select certain services they will not cover due to certain group plans. I agree to be responsible for any uncovered services rendered to me or my dependents, as well as any co-payments and deductibles as stipulated by my insurance company. I authorize McKim Family Chiropractic, S.C. to release any information, including but not limited to diagnosis, treatment and/or examination records pertaining to me or my dependents, to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to McKim Family Chiropractic, S.C., insurance benefits otherwise payable to me. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICY. I agree to give 24 hours notice of cancellation of appointments.

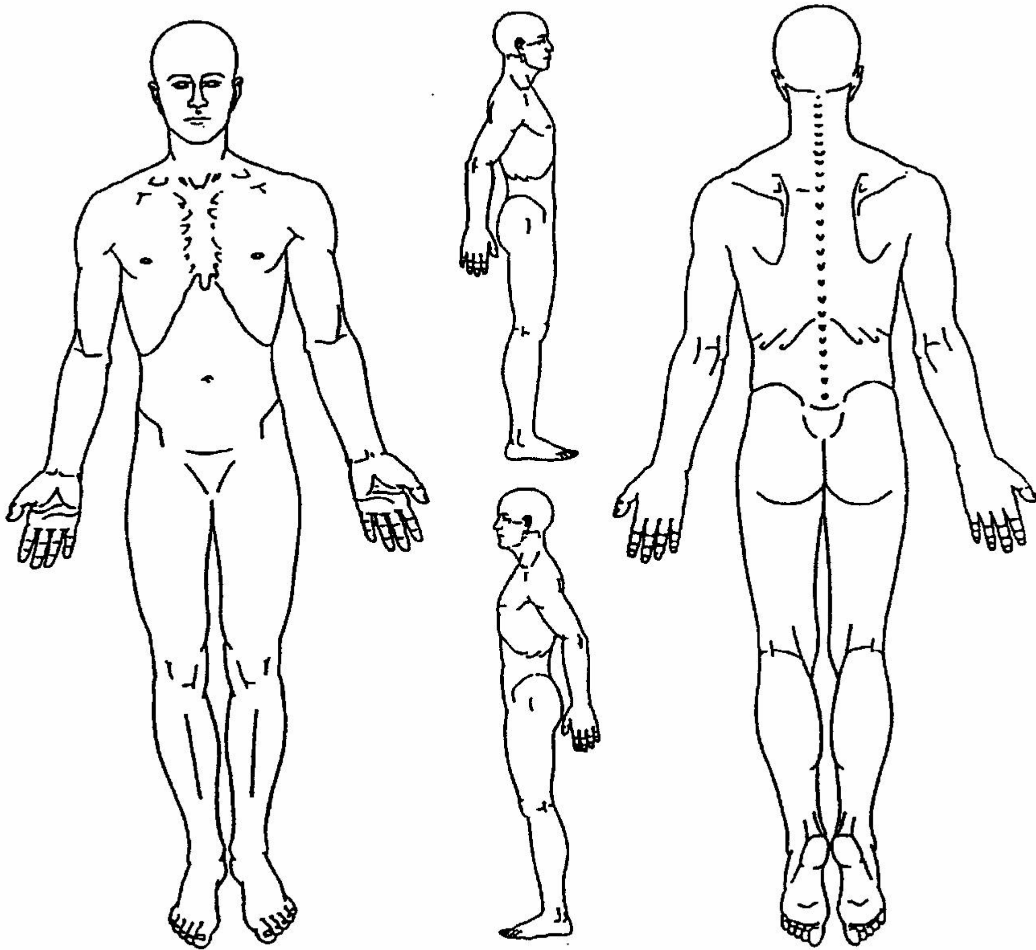
Patient Signature (Parent or Guardian if minor) ______________________________________ Date ____/____/________

Pain Diagram

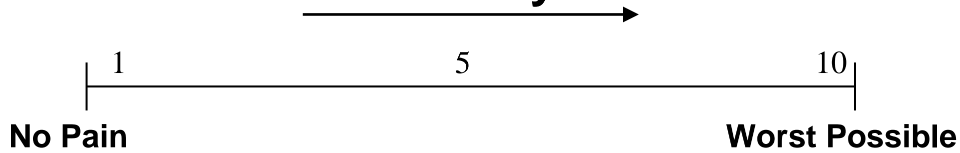
Name: ____ **Date**: ______/______/__________

Please circle the type of pain you are having and the locations of your pain on the figures below

Ache	Burning	Numbness	Pins and Needles	Sharp/Stabbing	Other



Pain Intensity Scale



No Pain **Worst Possible**

Please mark on the line at the level of pain you feel on a daily basis

HIPAA Privacy Policy / Notice of Private Health Information Disclosures Practices

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby understand that by signing this Consent, I acknowledge and agree as follows:

- The Practice's all-inclusive Privacy Notice is made available to me and includes a complete description of the uses and/or disclosures of my protected health information (PHI – which includes information about my health or condition and the treatment provided to me) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request, of my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the following information carefully prior to my signing this Consent.

- The practice is required to abide by this Consent and HIPAA guidelines, and reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. Any changes would be displayed visibly within the office.

- I understand that, and consent to, the following: appointment reminders by mail, or phone to home or work; birthday and holiday greetings; contact from the practice regarding information concerning the practice.

- The Practice may use and/or disclose my PHI in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

- I understand that disclosure of my PHI without my authorization is strictly limited to the defined situations, including, but not limited to: emergency care; quality assurance activities; public health, research, and law enforcement, governmental, and military activities. I also understand that thru the use of professional judgment, the practice may disclose my PHI to family members or personal representatives that have been present during office visits and/or treatment, and involved in my payment and/or treatment plan.

- I understand that I have a right to inspect, receive a copy of, and amend my personal records, and I also understand that I may request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested, and may charge a reasonable fee for records. I also understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all *future* transactions and that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

- I understand that I may file a complaint concerning privacy violations with the practice thru the HIPAA officer/Office Manager, and if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient or Legal Representative:____

Relationship if Legal Representative:____

Date:______/______/__________ **Effective Date of This Notice of Consent: 04/14/2003**