CHIROPRACTIC PATIENT UPDATE

Name: _____ Phone: _____

Do you have a change of address? Yes/No Do you have a change of insurance? Yes/No

Purpose of this appointment: _____

Is this the same problem you were originally under care for? Yes/No

Has it become worse recently? Yes/No Same/Better/Gradually Worse

If yes, when and how? _____

How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only _____

How long does it last? All Day _____ Few Hours_____ Minutes _____

Are there other unrelated health problems? Yes/No. If yes,describe_____

_____

Describe the pain: Sharp _____ Dull_____ Numbness_____ Tingling _____ Aching _____

Burning _____Stabbing _____ Other _____

Is there anything you can do to relieve the problem? Yes/No

If yes, describe _____ If no, what have you tried to do

that has not helped? _____

What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

Have you had any falls or accidents in the past month? Yes/No. If yes, please explain: _____

_____

_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes/No/Uncertain

Remarks: _____

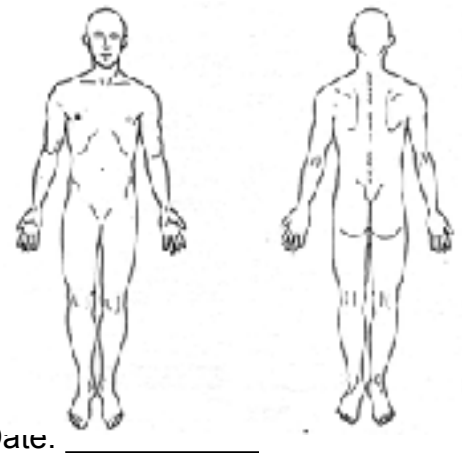
_____

No Symptoms Extreme Symptoms

Place an "X" on the line above to indicate your level of problem

Mark areas and type of pain on diagram to the right:

Ache > >	Burning x x
Numbness = =	Stabbing / /
Pins & Needles o o o o	Throbbing ~ ~



Patient/Guardian Signature:_____ Date. _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Please review options below and sign the one(s) you want to give us permission to contact you other than phone.

I, _____, give Lifetime Chiropractic permission to email me

at _____. I understand that unless both email addresses are secure, there is a possibility that it could be seen by other people.

I, _____, give Lifetime Chiropractic permission to text me

at_____. I understand that text messages are not secure and there is a possibility that they can be seen by other people.

Patient/Guardian Signature:_____ Date: _____