CONFIDENTIAL PATIENT CASE HISTORY

NAME _____ DATE_____ AGE_____ B-DAY_____

ADDRESS _____ CITY_____ ST _____ ZIP _____

CELL PHONE _____ EMAIL _____

HOME PHONE _____ WORK PHONE _____

OCCUPATION_____ EMPLOYER _____

EMPLOYER ADDRESS _____

MALE ___ FEMALE ___ MARITAL/SOCIAL STATUS _____

NO. CHILDREN & AGES _____ SPOUSE NAME _____

WHO IS RESPONSIBLE FOR ACCOUNT? SELF PARENT SPOUSE _____

ADDRESS (IF DIFFERENT) _____ RELATION _____

PRIMARY CARE PHYSICIAN _____

WHO TOLD YOU ABOUT OUR OFFICE? _____

EMERGENCY CONTACT _____ PH# _____

LIFESTYLE HABITS

TOBACCO (PACKS/DAY) _____ SLEEP (HOURS/DAY _____

ALCOHOL (DRINKS/DAY) _____ SOFT DRINKS (#/DAY) _____

COFFEE (CUPS/DAY) _____ EXERCISE: TYPE _____

FREQUENCY: _____

FAMILY HEALTH HISTORY

RELATION HEALTH PROBLEM

FATHER _____

MOTHER _____

SISTERS _____

BROTHERS _____

NAME _____

CHIEF COMPLAINT:

_____
_____
_____

HOW LONG HAS THIS BEEN BOTHERING YOU? _____ IS IT GETTING: WORSE/SAME/ BETTER

WHAT DO YOU THINK CAUSED THE PROBLEM?

_____
_____

HAVE YOU EVER FELT THIS BEFORE? _____ WHEN? _____

WHEN DO YOU FEEL THE WORST? MORNING AFTERNOON EVENING ALL THE TIME

WHAT MAKES YOU FEEL BETTER?

_____
_____

WHAT MAKES YOU FEEL WORSE?

_____
_____

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS? _____ WHO? _____

WAS ANY MEDICATION PRESCRIBED? _____ TYPE: _____

HAVE YOU HAD X-RAYS/CT/MRI? _____ WHERE? _____ WHEN? _____

HAVE YOU EVER SEEN A PHYSICAL OR OCCUPATIONAL THERAPIST FOR THIS CONDITION? _____

WHEN? _____ DID THOSE THERAPIES HELP? _____

HAVE YOU HAD ANY CAR ACCIDENT SINCE YOUR LAST VISIT? _____ WHEN? _____

IS THIS A WORK RELATED CONDITION/INJURY? _____ WHAT HAPPENED? _____

ARE YOU CURRENTLY PREGNANT? _____ IF SO WHAT IS YOUR DUE DATE: _____

DO YOU HAVE ANY OTHER COMMENTS TO TELL US ABOUT THIS CONDITION OR ANOTHER?

_____
_____

PLEASE CIRCLE THE SYMPTOMS/CONDITIONS YOU CURRENTLY HAVE. UNDERLINE ANY THAT YOU HAVE HAD IN THE RECENT PAST.

GENERAL

Headaches
Unexplained Fevers
Nights Sweats
Weight Loss > 10 lb
Loss of Appetite
Excessive Fatigue
Depression
Unusual Stress @ Work
Unusual Stress @ Home
Dizziness/Vertigo
Pain That Wakes You Up From Sleep
Mental Fogginess
Personality Changes
Infertility

MUSCLE & JOINT

Joint Pain
Spinal Curvature/scoliosis
Hernia
Knots in Muscles
Knee Pain
Hip Pain
Pain in both hands
Shoulder Pain
Back Pain
Neck Pain
Generalized Muscle Aches

RESPIRATORY

Persistent Cough
Difficulty Breathing
Coughing up Blood
Coughing up Phlegm
Pain with Breathing
Shortness of Breath

CARDIOVASCULAR

Poor Circulation
Chest Pain with Activity
Shortness of Breath with Activity without Activity
High Cholesterol
Swelling in ankles/legs
Feelings of Doom

GENITOURINARY

Pain with Urination
Difficulty Controlling Urination
Blood in Urine
Rapid Heart Beat
Dark Urine
Kidney Stones
Bladder Infections
Difficulty Initiating Urination

GASTROINTESTINAL

Difficulty swallowing
Abdominal pain/discomfort
Nausea/vomiting
Mental Fogginess after meal
Diarrhea
Constipation
Dark Black stools
Blood in Stools
Tan Stools
Gall stones
Gas/Bloating/Poor Digestion
Acid Reflux/Acid Indigestion
Ulcers (apthous) in mouth

EAR, NOSE, EYES, & THROAT

Unusual Hoarseness
Strep Throat
Enlarged glands/tonsils
Thyroid Problems
Vision changes/problems
Double Vision
Ringing in Ears/Tinnitus
Ear Discharge
Sinus Infection

SKIN

Lump/thickening in Breast/Armpit
Change in Mole
Bruise Easily
Hair Loss
Sore That Doesn't Heal
Rash/Hives
Psoriasis

MEN ONLY

Prostate Trouble
Pain with Sex
Testicular Pain/Lump
Urinary Frequency
Erectile Dysfunction

FEMALE ONLY

Breast Implants
Vaginal Bleeding not during period
Lump in Breast
Date of last period _____
Date of Last Pap Smear _____
On Birth Control Pills? Y N
Perform Breast Self Exams? Y N

SURGERIES/HOSPITALIZATIONS

What For:_____ Year: _____
What For:_____ Year: _____
What For:_____ Year: _____
What For:_____ Year: _____

FRACTURES/OTHER INJURIES

What Fractured? _____ Year _____
What Fractured? _____ Year _____
What Fractured? _____ Year _____
What Fractured? _____ Year _____

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION & NONPRESCRIPTION), VITAMINS, SUPPLEMENTS, HERBS, ETC. THIS IS VERY IMPORTANT!

NAME:	REASON	DOSAGE	HOW LONG HAVE YOU TAKEN THIS?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HAVE YOU EVER BEEN TO A CHIROPRACTOR BEFORE? WHO & WHEN?
I am interested in some of the following (check any that are appropriate):

- ○ **I am interested in anything the doctor recommends to diagnose or treat my condition**
- ○ **Basic Physical Medicine Evaluation** (for Musculoskeletal Pain, Headaches, etc.): evaluating for musculoskeletal sources of pain, and therapies including Acupuncture, Chiropractic, Massage, etc.
- ○ **Weight Loss Program** (acupuncture and manipulation assessment to stimulate metabolic rate via nervous and endocrine systems, blood/urinalysis including glucose, CBC, HbA1C, and thyroid panel, dietary consultation and exercise recommendations, hormonal consultation)
- ○ **Fertility Program (acupuncture, blood and urinalysis, complete physical exam, biomechanical evaluation for altered pelvic and spinal biomechanics, possible thyroid and gluten-sensitivity tests)**
- ○ **Total Health Evaluation** (this is a timely and extensive evaluation, including complete physical examination, blood and urine evaluation, NRT reflex testing, autonomic function assessment, salivary pH, orthostatic testing, and more as indicated): This is for very sick individuals or people that have been told that they "don't have a problem", "it's all in your head", or "you're a hypochondriac"
- ○ **Athlete Evaluation**: (Usually for professional or semi-professional athletes): Assesses overtraining, autonomic function, acid-base balance, fuel substrate evaluation for long term energy and overtraining, physical exam, blood chemistry evaluation for athletes, gait analysis, orthostatic hypotension, spirometric evaluation, as indicated (EKG and/or Respiratory Quotient)
- ○ **Nutritional Response Testing**
- ○ **Blood Chemistry/Urinalysis Evaluation** (This checks hormones, cholesterol, etc. and is recommended if over 30 years old and you have not have a general blood work up)
- ○ **Acupuncture**
- ○ **Cancer Screening** (imaging and/or cancer marker testing, the AMAS test is 95%+ accurate in detecting ***any*** cancer at very early stages)
- ○ **Cardiac Screening** (detailed blood analysis and/or EKG/spirometry for individuals with a strong family history of cardiac problems or concern about chest/thoracic pain)
- ○ **Toxic Metal Screening (Hair analysis)**
- ○ **Cellular Analysis of your Nutritional status, including vitamins, minerals, and amino acids (confused about what vitamins to take? This test is for you.)**
- ○ **Paternity Testing/Genetic Screening for Diseases/Family Heritage Genetic Testing**

NOTICE OF PRIVACY PRACTICES
EFFECTIVE September 30, 2008

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT.

UNDERSTANDING YOUR HEALTH RECORD INFORMATION

Each time you visit a hospital, physician, or other health provider, a record of your visit is made. It contains information about your symptoms, treatment, diagnostics, diagnoses, and health history. This protected health information (PHI) serves as:

- A basis for nutritional and physical medicine interventions and treatments
- A means of communicating amongst other health professionals
- A legal document describing care received
- A means by which third party payers can verify that services were rendered
- A educational tool to other providers and professionals
- A source of information to public health officials
- A tool by which we evaluate treatments and improve quality of care

WE WILL USE AND DISCLOSE YOUR INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. We are permitted to use your health information without your specific authorization for the purposes of treatment, payment for services rendered, and healthcare operations.

EXAMPLES:

- We will use your information for treatment. Your record can be used amongst providers of service and staff involved in your care. We may also provider this information to other health providers involved in your care at their request.
- We will use you information for payment. A bill may be sent to you or your insurance company for unpaid services. The information on the bill or accompanying it may be used to identify you, and may include diagnoses, procedures, and supplies involved in your care.
- Your information will be used for regular health operations. It can be used for scheduling, quality assessments, case management or coordination, diagnostic procedures ordered, auditing of records for coding and billing purposes, or to assess outcomes measurements.

WE CAN DISCLOSE YOU PHI TO:

- BUSINESS ASSOCIATES: These are companies that we deal with in ordering or performing diagnostic , laboratory or other health services that require information regarding you or your medical record for processing and initiating service.
- NOTIFICATION PURPOSES: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, or general condition.
- COMMUNICATION WITH FAMILY: We may disclose to a family member, close personal friend, or other relative information pertaining to their involvement in your care or payment for care.
- RESEARCH: information may be disclosed for research data collection and processing to improve healthcare costs or services for teaching or research endeavors.
- MARKETING: We may contact you via mail, phone, or email with regards to appointment reminders, Blood work or urinalysis results, treatment options, health services offered, or other health related information that may be of interest to you.
- FOOD and DRUG ADMINISTRATION: with regards to drug, supplement, or other equipment recalls
- WORKERS COMPENSATION
- PUBLIC HEALTH AUTHORITIES: we will disclose information as required by law to health or law authorities charged with preventing or controlling disease, injury, or disability.

- LAW INFORCEMENT: As required with subpoena or other legal request for documentation.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare provider or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on use or disclosure of certain information
- Obtain a hard copy of the information ($25 charge for copying and compiling treatment records and additional $25 charge for billing records)

These requests may take a reasonable amount of time depending on staff and other restrictions.

OUR RESPONSIBILITY:

We are required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may to communicate health information by alternative means or at alternate locations

We also reserve the right to change our policies and to make the new provisions effective for all of your health information we already have, as well as any health information we receive and create in the future. Should our privacy policies change, we will post a copy of the revised notice in the office. You may request and obtain a copy of the Notice of Privacy Practices anytime you visit our office.

HIPAA OFFICE POLICIES

By signing below I, _____ acknowledge that I have read and have had an opportunity to ask questions regarding JOEL CONE, D.C.'s policy notice according to HIPAA regulations and laws. I fully understand that I may retract my consent at any time.

Signature: _____

In compliance with HIPPA, our staff requires written permission from the patient or legal guardian to perform certain services. Please complete this form for our records.

May our staff leave messages including personal appointment dates and times?

_____ Yes, on the answering machine/voicemail

_____ Yes, with a family member

_____ No, please do not leave messages

May our staff leave messages regarding diagnostic results, including radiology, MRI, CT, blood chemistry or urinalysis findings?

_____ Yes, on the answering machine/voicemail

_____ Yes, with a family member

_____ No, please do not leave messages

Will you allow your appointments to be scheduled and/or cancelled by anyone besides yourself?

_____ No

_____ My M.D./Medical Provider

_____ My spouse

_____ My secretary

_____ other: _____

Patient, parent or guardian signature: _____Date: _____