

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex M F Marital Status M S D W Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Have you ever received Chiropractic Care? Yes No If yes, when? \_\_\_\_\_

Name of most recent Chiropractor: \_\_\_\_\_

**1. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Since the Motor Vehicle Collision, have you experienced any of the following:**

- A. Loss of Range of Motion: yes/no
  - a. What body parts: \_\_\_\_\_
- B. Visual Disturbance : yes/no (please explain): \_\_\_\_\_
- C. Dizziness: yes/no How often: \_\_\_\_\_
- D. Anxiety: yes/no How often: \_\_\_\_\_
- E. Depression: yes/no How often: \_\_\_\_\_
- F. Difficulty Sleeping: yes/no How often: \_\_\_\_\_

**3. Past Health History:**

**A. Please indicate if you have a history of any of the following:**

- Anticoagulant use  Heart problems/high blood pressure/chest pain  Bleeding problems
- Lung problems/shortness of breath  Cancer  Diabetes  Psychiatric disorders
- Bipolar disorder  Major depression  Schizophrenia  Stroke/TIA's  Other \_\_\_\_\_
- None of the above

**B. Previous Injury or Trauma:**

\_\_\_\_\_

**Have you ever broken any bones? Which?**

\_\_\_\_\_

**C. Allergies:** \_\_\_\_\_

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**D. Medications:**

Medication	Reason for taking

**E. Surgeries:**

Date	Type of Surgery

**F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome

**4. Family Health History:**

Do you have a family history of? (Please indicate all that apply)

- Cancer    Strokes/TIA's    Headaches    Cardiac disease    Neurological diseases
- Adopted/Unknown    Cardiac disease below age 40    Psychiatric disease    Diabetes
- Other \_\_\_\_\_    None of the above

Deaths in immediate family: \_\_\_\_\_

Cause of parents or siblings death	Age at death

**5. Social and Occupational History:**

**A. Job description:**

\_\_\_\_\_

**B. Work schedule:**

\_\_\_\_\_

**C. Recreational activities:**

\_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

\_\_\_\_\_

**Review of Systems**

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing  COPD  Emphysema  Other \_\_\_\_\_  None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries  Congestive heart failure  Murmurs or valvular disease  Heart attacks/MIs  Heart disease/problems  Hypertension  Pacemaker  Angina/chest pain  Irregular heartbeat  Other \_\_\_\_\_
- None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision  One-sided weakness of face or body  History of seizures  One-sided decreased feeling in the face or body  Headaches  Memory loss  Tremors  Vertigo  Loss of sense of smell
- Strokes/TIAs  Other \_\_\_\_\_  None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease  Hormone replacement therapy  Injectable steroid replacements  Diabetes
- Other \_\_\_\_\_  None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones  Hematuria (blood in the urine)  Incontinence (can't control)  Bladder Infections
- Difficulty urinating  Kidney disease  Dialysis  Other \_\_\_\_\_  None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea  Difficulty swallowing  Ulcerative disease  Frequent abdominal pain  Hiatal hernia  Constipation
- Pancreatic disease  Irritable bowel/colitis  Hepatitis or liver disease  Bloody or black tarry stools
- Vomiting blood  Bowel incontinence  Gastroesophageal reflux/heartburn  Other \_\_\_\_\_  None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia  Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)  HIV positive
- Abnormal bleeding/bruising  Sickle-cell anemia  Enlarged lymph nodes  Hemophilia
- Hypercoagulation or deep venous thrombosis/history of blood clots  Anticoagulant therapy  Regular aspirin use
- Other \_\_\_\_\_  None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns  Significant rashes  Skin grafts  Psoriatic disorders  Other \_\_\_\_\_  None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis  Gout  Osteoarthritis  Broken bones  Spinal fracture  Spinal surgery  Joint surgery
- Arthritis (unknown type)  Scoliosis  Metal implants  Other \_\_\_\_\_  None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis  Depression  Suicidal ideations  Bipolar disorder  Homicidal ideations  Schizophrenia
- Psychiatric hospitalizations  Other \_\_\_\_\_  None of the above

Is there anything else in your past medical history that you feel is important to your care here? \_\_\_\_\_

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I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Glen Matejka D.N., D.C., D.A.C.B.N., CCN at Comprehensive Back and Nutritional Family Care for services performed.

Patient or Guardian Signature \_\_\_\_\_  
Date \_\_\_\_\_

**HIPAA NOTICE OF PRIVACY PRACTICES**

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 CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**NEW PATIENT HISTORY FORM**

Symptom 1 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):

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- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 2 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, walking, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 3 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_

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- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 4 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):



**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 5 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 6 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
  - Did you have this symptom before this motor vehicle collision? Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist,

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sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day