Arcadia Health and Wellness Chiropractic
3520 E. Indian School Rd. Ste C
Office (602) 954-9444 - Fax (602) 954-1248

CONFIDENTIAL PATIENT APPLICATION FOR TREATMENT

Today's Date: _____ Date of Birth ____ / _____ / _____
Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work/Cell Phone: _____
Marital Status: Married Single Widowed Divorced Do you have children? Yes No
Have you ever received chiropractic care? Yes No How long has it been? _____
Have your family members had chiropractic care? Yes No

When was your last physical examination? _____
Do you smoke? Yes No How Much? _____ Do you drink alcohol? Yes No How Much? _____
Do you exercise? Yes No How Often? _____ What type of exercise? _____
If female, are you pregnant? Yes No Date of last cycle? _____
Do you have any allergies? (Specify) _____
Have you ever suffered from or been diagnosed as having: (please circle yes or no for each)

Y N Broken or Fractured Bones
Y N Rheumtoid Arthritis
Y N High/Low Blood Pressure
Y N Diabetes
Y N Osteoarthritis
Y N Strokes
Y N Cancer

Please explain any Yes answers: _____

PATIENT HISTORY

What is your primary complaint? _____
On the scale below, please circle the severity of your main complaint of your primary complaint: (at its worst)

None		Slight		Mild		Moderate			Severe
1	2	3	4	5	6	7	8	9	10

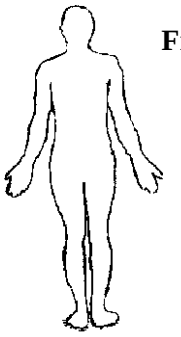
What **percentage of time** do you experience your primary complaint? (0 % - 100 %) _____

How **long** have you been experiencing your primary complaint? _____

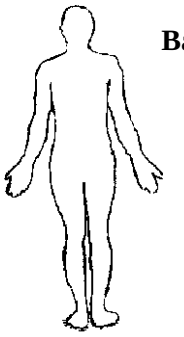
On the diagram below, please show **where** you are experiencing ALL of your present complaints using the code below:

A: Ache B: Burning Pain C: Cramping D: Dull Pain R: Throbbing Pain N: Numbness T: Tingling

Front



Back



Do you have pain or difficulty performing:

__ Personal Care __ Lifting
__ Reading __ Concentrating
__ Working __ Driving
__ Sleeping __ Recreation
__ Walking __ Sitting
__ Standing __ Social Life

What makes it feel better? _____
Have you ever had this problem in the past? Yes No
Have you lost time from work? Yes No

What makes it feel worse? _____
If yes, then when? _____
How much time have you lost? _____

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Phoenix AZ, 85018

Systems Review

In the left hand column, please indicate with a (Q) for conditions that you have now or with a (P) for the conditions that you have had in the past. If neither apply, mark (NA). Please do not leave any blanks.

High Blood Pressure	_____
Dizziness/Fainting	_____
Insomnia	_____
Muscle Tension	_____
Confusion	_____
Fatigue	_____
Ulcers	_____
Eye/Vision Problems	_____
Ear/Hearing Problems	_____
Difficulty Breathing	_____
Heart Problems	_____
Loss of Bladder Control	_____
Constipation	_____
Diarrhea	_____
Digestion Problems	_____
Nausea	_____
Female Problems	_____
Prostate Problems	_____
Diabetes	_____
Cold Hands/Feet	_____
Hand Tremors	_____
Loss of Memory	_____
Nervousness	_____
Sweaty Palms	_____
Speech Difficulty	_____
Anxiety	_____
Depression	_____
Irritability	_____

FOR DOCTOR'S USE ONLY

Review Of Systems	Symptoms
General	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity
Skin	Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
Head	Trauma, headaches, dizziness, light headed
	Change in acuity of vision, use of corrective lenses, loss of diplopia, photophobia, blurred vision, scotomatic pain.
Eyes	Excessive lacrimation, redness, discharge
Nose	Rhinorrhea, epistaxis, allergies, airway obstruction
Mouth/ Throat	Ulcers, tooth pain/extractions, temporomandibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore Mouth & Throat throat, strep throat
Neck	Stiffness, iumps/swelling/masses, pain
Lungs	Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, w heezing, night sweats
Cardiac	Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling syncope
Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
Breasts	Self-examination frequency / results, pain, nipple discharge, lumps/masses, skin dimpling
Gastrointestinal	Unusual diet, sysphagia, regurgitation, dyspepsia, nausia, vomiting, belching, abdominal pain, cramps, hermaterrasis, stool color changes, diarrhea, sonstipatbn, change in bowel habits, jaundice, abdominal swelling
Genitournary	Polyuria, nocturia, oliguria, dysuria, uregency, incontinence, urine color changes, hermaturea, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia
Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstration history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric
Hematopoietic	Anemia, abdominal bleeding, lymph node, elargement / pain
Musculoskeletal	Bone/joint pain, swelling, joint deformity, trauma, restricted l range of motion, weakness, atrophy
Neurological	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, loss of balance, numbess, l paresthesia
Psychological	Mood swings, depression, anxiety, phobias

I certify that all of the information given on both pages is true and accurate to the extent of my knowledge. I have submitted this information to Arcadia Health and Wellness Chiropractic to be contained in my confidential patient file with the understanding that this and all of my private health information will maintain in a confidential patient file that is accessible only to Arcadia Health and Wellness Chiropractic unless I authorize otherwise. I understand and agree that all services rendered here are charged directly to me and that I am personally responsible for payment. For Worker's compensation and Health Insurance or personal cases, I authorize all records and bills of mine to be public record if necessary to allow my provider to get paid in full on my case. If I refuse this public notification, I acknowledge that I am personally responsible for all services rendered by Arcadia Health and Wellness Chiropractic. All incurrence's and billable services will be paid at time of service. I hereby authorize the Doctor to treat my condition as he or she deems appropriate. My signature also authorizes this office to bill my health insurance for services rendered.

Signature of Patient or Guradian_____ Printed Name_____

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Emergency Contact Information

Patient's Name:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ email _____

Home Address: _____

Spouse's Name: _____

Cell Phone: _____Work Phone: _____

Nearest relative not living with you _____

Phone #_____

Physician: _____ Phone #_____

Who may we contact in case of emergency ? Name: _____

Home Phone # _____Cell Phone #_____

Who may we thank for referring you to AHWC ?_____

Who is responsible for your bill ?_____

I will be paying by: ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD**

HIPAA Notice of Privacy Practices

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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 practices describes how we may use and disclose your protected health information **(PHI)** to carry out treatment, payment or health care operations **(TPO)** and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health care 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 for you. For example, your protected health 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 use or 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, and conducting or arranging for other business activities. For example, we may disclose your protected health care 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 include: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity : Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make a disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164-500.

Other Permitted and Required Uses **and Disclosures** will be made 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.

YOUR RIGHTS

Following is a statement to your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physical] amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Yon have the right to receive an accounting of certain disclosures we have made, if any, of your protected **health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14,2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print Name: _____ Signature:_____ Date:_____