Who may we thank for referring you into this office? _____

Anchor CHIROPRACTIC

Today's Date: _____ **HRN:** _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married Do you have insurance: ☐ Yes ☐ No Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of Children and Ages: _____

Emergency Contact Name: _____ Number: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office, on a scale of **0** to **10** with **10** being the worst pain and **0** being no pain; rate your complaint by **circling the number**.

Primary Complaint: _____ **Scale** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Secondary Complaint: _____ **Scale** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third Complaint: _____ **Scale** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

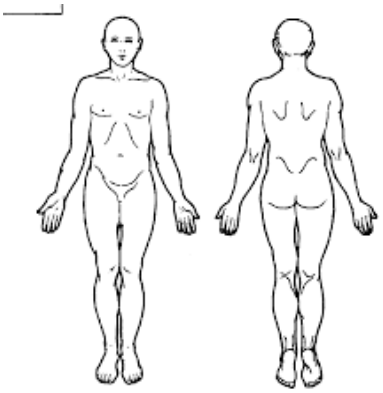
When did the problem begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-Day ☐ Late PM

How long does it last? ☐ It is constant ☐ I experience it on and off during the day ☐ it comes and goes throughout the week

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes If yes, When: _____ by Whom: _____

PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:

R: **R**adiating **B**: **B**urning **D**: **D**ull **A**: **A**ching **N**: **N**umbness **S**: **S**harp/**S**tabbing **T**: **T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Is your problem the result of ANY type of accident/injury? ☐ Yes ☐ No

Explain: _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____

Have you suffered with any of this or a similar problem in the past ☐ Yes ☐ No

If yes, explain: _____

PAST HISTORY

Have you been to a chiropractor in the last 5 years? ☐ Yes ☐ No

Have you tried other forms of treatment? ☐ Yes ☐ No **If yes**, explain type of treatment: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body?

_____

Have you had any major surgeries? ☐ Yes ☐ No If yes, Explain: _____

SOCIAL HISTORY

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Alcoholic Beverage: Consumption occurs: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Recreational Drug Use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No If yes, whom: _____

Have you ever been treated for their condition: ☐ Yes ☐ No ☐ I don't know

Any other hereditary conditions the doctor should be aware of? ☐ Yes ☐ No If Yes, Explain: _____

FINANCIAL AGREEMENT

I hereby authorize payment to be made directly to Anchor Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Anchor Chiropractic for any and all services I receive at this office.

1. I understand that is my account is assigned to a collection agency, that the collection agency will charge a commission or fee that may be as much as 50 percent of the amount I owe to Anchor Chiropractic. I agree that if my account is assigned to a collection agency, that Anchor Chiropractic may add the amount of the collection agency's commission or fee to the amount that I owe Anchor Chiropractic, and I agree to pay that additional amount.
2. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____

Doctor's Signature Date Reviewed

Patient's Name: _____ HR#:_____ Date:_____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (Can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

_____ _____/_____/_____

Patient Signature Today's Date

If you have ever been diagnosed with any of the following conditions, **PLEASE INDICATE** which ones apply to you:

List	Past	Current
ADD/ADHD	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Back Curvature	☐	☐
Bed Wetting	☐	☐
Blood Disorder	☐	☐
Blood Pressure (high/low)	☐	☐
Blurred Vision	☐	☐
Broken Bone	☐	☐
Cancer	☐	☐
Cerebral Vascular	☐	☐
Chest Pain	☐	☐
Colon Trouble	☐	☐
Convulsions/Epilepsy	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Diarrhea/Constipation	☐	☐
Difficulty Breathing	☐	☐
Digestive Problems	☐	☐
Disability	☐	☐
Dislocations	☐	☐
Dizziness	☐	☐
Double Vision	☐	☐
Eating Disorder	☐	☐
Fainting	☐	☐
Foot/Knee Problems	☐	☐
Fracture	☐	☐
Frequent Colds/Flu	☐	☐
Gall Bladder Trouble	☐	☐
Headache	☐	☐
Hearing Loss	☐	☐
Heart Attack	☐	☐
Heartburn	☐	☐
Heart Problems	☐	☐
Hepatitis (A,B,C)	☐	☐

List	Past	Current
Hip Pain	☐	☐
Irritable	☐	☐
Impotence/Sexual Dysfun.	☐	☐
Jaw Pain, TMJ	☐	☐
Kidney Trouble	☐	☐
Learning Disability	☐	☐
Liver Trouble	☐	☐
Loss of Balance	☐	☐
Low Back Pain	☐	☐
Lung Problems	☐	☐
Menopausal Problems	☐	☐
Menstrual Problem	☐	☐
Mid Back Pain	☐	☐
Mood Changes	☐	☐
Neck Pain	☐	☐
Numb/Tingling	☐	☐
(arms, hands, fingers)	☐	☐
Numb/Tingling	☐	☐
(legs, feet, toes)	☐	☐
Osteo Arthritis	☐	☐
Pain with Sneeze/Cough	☐	☐
PMS	☐	☐
Pregnant (now)	☐	☐
Prostate Problems	☐	☐
Rheumatoid Arthritis	☐	☐
Ringing in ears	☐	☐
Scoliosis	☐	☐
Shoulder Pain	☐	☐
Sinus/Drainage Problems	☐	☐
Skin Problems	☐	☐
Swollen/Painful Joints	☐	☐
Tremors	☐	☐
Trouble Sleeping	☐	☐
Tumors	☐	☐
Ulcers	☐	☐
Upper Back Pain	☐	☐

What do you want to improve in your time under care:

Breathe Better
Have more energy
Better Immune Function
Better Digestion
Sleep Better
Exercise
Better Mobility
Better Posture
Do more activities: if yes, which activities: _____
Other: _____

PAIN SCALE

Patient Name: _____ Date: _____

Please Read Carefully:

Instructions: Please circle the number that best describe the question being asked.
0 – Being NO Pain and 10 – Worst Possible Pain

1. What is your pain **RIGHT NOW**?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain lever **AT ITS BEST** (How close to "0" does your pain get at its best)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain lever **AT ITS WORSE** (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Other Comments:

_____

_____

Examiner:

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all form of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Anchor Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/___/___ _____

Patient or Authorized Person's Signature Date Witness Initials

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ___-___-___ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ___/___/___ _____

Patient or Authorized Person's Signature Date Witness Initials

ANCHOR CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstance. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception area.

PERMITTED DISCLOSURES:

1. **Treatment purposes** – discussion with other health care providers involved in your care.
2. **Inadvertent disclosures** – open treating are mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. **For payment purposes** – to obtain payment from your insurance company or any other collateral source.
4. **For workers compensation purposes** – to obtain payment from your insurance company or any other collateral source.
5. **Emergency** – in the event of a medical emergency we may notify a family member.
6. **For Public health and safety** – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. **To Government agencies or Law enforcement** – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. **Decreased persons** – discussion with coroners and medical examiners in the event of a patient's death.
10. **Telephone calls or emails and appointment reminders** – **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. **Change of ownership** – in the event this practice is sold, the new owners would have access to your **PHI**.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call John Morelli, D.C. at (702) 778-8664. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles y9our complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient Name: _____ Date of Birth: _____

ANCHOR CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of Anchor Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____
Patient's Signature Date

MEDICAL RELEASE

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child(ren):_____

[ ] Other:_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call: [ ] My Home:_____ [ ] My Work:_____ [ ] My Mobile Number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

_____ _____ _____
Patient's Signature Date HR#

_____ _____
Witness Signature Date