

New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

Patient Data

First Name Last Name Date Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address City State Zip

Telephone (Work) (home) Referred By

Age Birth Date Social Security # Number of Children

Occupation Employer

Marital Status Spouse's Name Spouse's Occupation

Spouse's Employer Spouse's Health Status

Emergency Contact Phone

Current Complaints

Nature of Injury: Automobile* Work Other

Please describe:

Date of Injury Date symptoms appeared

Have you ever had same condition? No Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? No Yes

If yes, please describe

Insurance Information

Name of party responsible for payment Phone

Do you have health insurance? No Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name Contact Person

Phone: Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

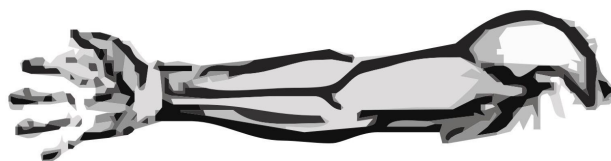
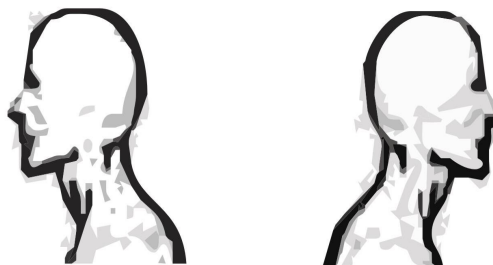
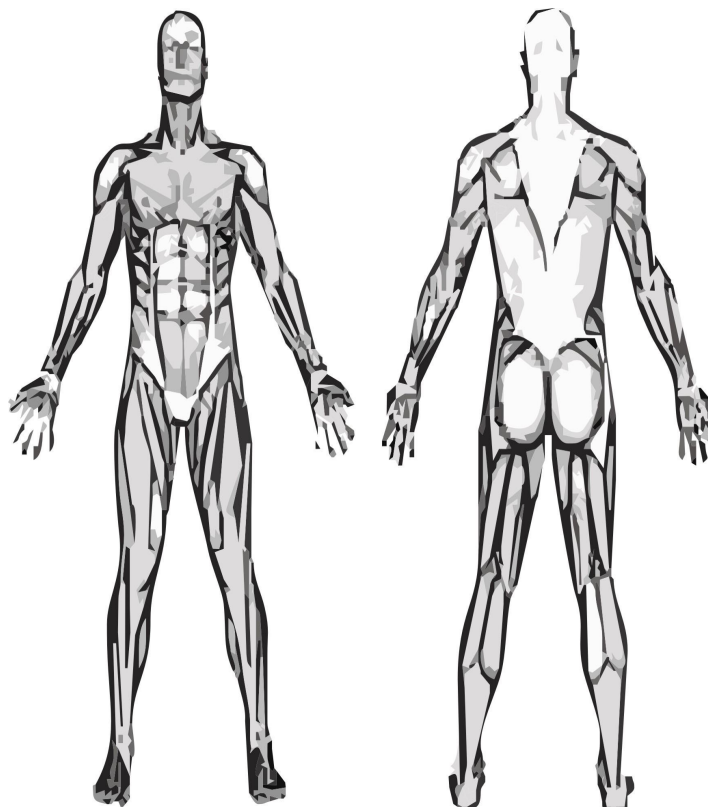
Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing



Notice of privacy practices

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The Peninsula Pain Rehabilitation Center

Notice Of Privacy Practices

10 As required by the privacy regulations created as a result of the Health Insurance
Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

15 Our practice is dedicated to maintaining the privacy of your individually identifiable
health information (also called *protected* health information, or PHI). In conducting our
business, we will create records regarding you and the treatment and services we provide
to you. We are required by law to maintain the confidentiality of health information that
identifies you. We also are required by law to provide you with this notice of our legal
20 duties and the privacy practices that we maintain in our practice concerning your PHI. By
federal and state law, we must follow the terms of the Notice of Privacy Practices that we
have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following
important information:

- 25
- How we may use and disclose your PHI,
 - Your privacy rights in your PHI,
 - Our obligations concerning the use and disclosure of your PHI.

30 **The terms of this notice apply to all records containing your PHI that are created or
retained by our practice. We reserve the right to revise or amend this Notice of
Privacy Practices. Any revision or amendment to this notice will be effective for all
of your records that our practice has created or maintained in the past, and for any
of your records that we may create or maintain in the future. Our practice will post
a copy of our current Notice in our offices in a visible location at all times, and you
35 may request a copy of our most current Notice at any time.**

**B. If you have questions about this Notice, please contact:
[insert name or title, address and telephone number of a person or office to
contact for further information].**

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C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Optional Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Optional Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Optional Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Optional Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,

• Reporting reactions to drugs or problems with products or devices,
 • Notifying individuals if a product or device they may be using has been recalled,
 • Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,

• Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Optional Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Optional Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Optional Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. **Serious threats to health or safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' compensation.** Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Peninsula Pain and Rehabilitation Center, 11015 Warwick Blvd, Newport News, VA 23601, Ph: 757-591-7291** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Peninsula Pain and Rehabilitation Center, 11015 Warwick Blvd, Newport News, VA 23601, Ph: 757-591-7291. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Peninsula Pain and Rehabilitation Center, 11015 Warwick Blvd, Newport News, VA 23601, Ph: 757-591-7291 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Peninsula Pain and Rehabilitation Center, 11015 Warwick Blvd, Newport New, VA 23601, Ph: 757-591-7291. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Peninsula Pain and Rehabilitation center, 11015 Warwick Blvd, Newport News, VA 23601, Ph: 757-591-7291. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-

month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.

5 To obtain a paper copy of this notice, contact Peninsula Pain and Rehabilitation Center 11015 Warwick Blvd, Newport News, VA 23601, Ph: 757-591-7291.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Peninsula Pain and Rehabilitation Center, 11015 Warwick Blvd, Newport News, VA 23601, Ph: 757-591-7291. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

10 **8. Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* we are required to retain records of your care.

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20 Again, if you have any questions regarding this notice or our health information privacy policies, please contact Peninsula Pain and Rehabilitation Center, 11015 Warwick Blvd, Newport News, VA 23601, Ph: 757-591-7291.

25 Note: *This document is a template only. It does not reflect the requirements of your state's laws. You should consult with advisors (e.g., your state or local medical or specialty society, or legal or other counsel) familiar with your state's privacy laws prior to using this document.*

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Authorization form

Peninsula Pain And Rehabilitation Center

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Peninsula Pain And Rehabilitation Center to use and/or disclose certain protected health information (PHI) about me to _____.

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This authorization permits Peninsula Pain and Rehabilitation Center to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

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(If disclosure is requested by the patient, purpose may be listed as “at the request of the individual.”)

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire 1 year from date signed.

20

I do not have to sign this authorization in order to receive treatment from Peninsula Pain and Rehabilitation Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to

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revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

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Peninsula Pain and Rehabilitation Center
11015 Warwick Blvd
Newport News, VA 23601
Ph: 757-591-7291

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Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

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Print Patient's Name Date

Print Name of Patient or Legal Guardian, if applicable

- 5 Patient/guardian must be provided with a signed copy of this authorization form.

Note: *This document is a template only. It does not reflect the requirements of your state's laws. You should consult with advisors (e.g., your state or local medical or specialty society, or legal or other counsel) familiar with your state's privacy laws prior to using this document.*

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