Frenchtown Chiropractic New Patient intake questionnaire

General Information:

Date: _____

Patient Name: _____ **DOB:** _____

Preferred Name: _____ **SSN:** _____-___-_____

Sex: M / F **Age:** _____ **Email:** _____

Address: _____

City: _____ **State**: _____ **Zip:** _____

Cell #: _____ **Home #:** _____ **Work #:** _____

Employer: _____ **Occupation:** _____

Emergency contact name: _____ **Relation:** _____

Emergency contact #: _____

Primary Care Doctor: _____ **Office Number:** _____

Office location: _____

How did you hear about us? _____

_____

_____

Current Complaint:

Please describe your current complaint and how it began: _____

_____

_____

_____

_____

_____

_____

How long have you had this condition? _____ **Date of onset:** _____

Have you experienced a similar complaint in the past? Y / N

If yes, how long ago and what did you do to resolve it: _____

_____

_____

How would you describe the complaint? (Circle all that apply)

Sharp	Shooting	Numb	Tingling	Burning	Weakness
Spasm	Throbbing	Deep	Dull	Achy	

Other: _____

How often is the complaint present?

Constant (81-100%) Frequent (51-81%) Occasional (25-50%)

Intermittent (25% or less)

How would you rate the intensity of your complaint? (0 = nonexistent, 10 = worst pain ever experienced)

0 1 2 3 4 5 6 7 8 9 10

How has your complaint effected your daily activities? _____

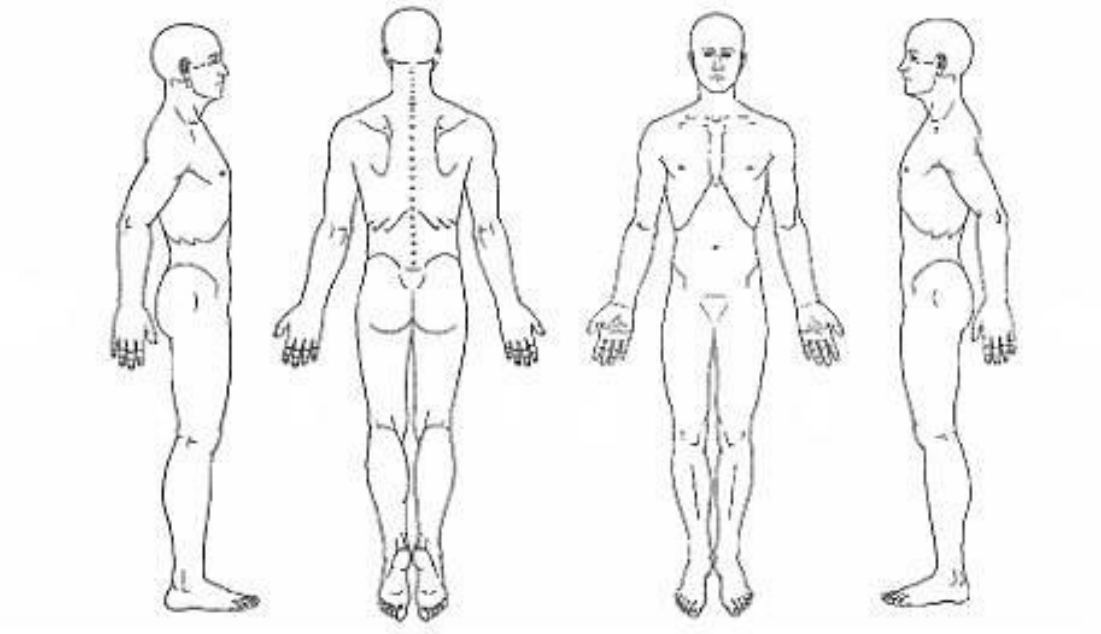
_____

_____

_____

_____

Please identify where your pain is present: you may also write additional information below the diagram in the space provided.



When does the complaint present?

Any time-of-day Mornings Midday Afternoon Evening

At night/in bed

Since the problem began, is your complaint:

Getting better Getting Worse No change/staying the same

What reduces the severity of your complaint? (Circle all that apply)

Nothing Walking Sitting Standing Exercise Lying down

Other: _____

What increases the severity of your complaint? (Circle all that apply)

Nothing Walking Sitting Standing Exercise Lying down

Other: _____

Have you taken any medication for your complaint (over the counter or prescription)? Y / N

If yes, please list what medication, how much, and how often: _____

_____

_____

_____

General Health history:

Are you currently being treated for any medical conditions? Y / N

If yes, please describe the condition and who you are being treated by: _____

_____

_____

_____

_____

_____

Current Medications:

Medication:	Dosage:	Medication:	Dosage:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug allergies: (please list reaction as well): _____

_____

_____

Other allergies: _____

_____

_____

Prior Surgeries/ Hospitalizations/ major accidents or injuries (fractures, etc.…)

Incident:	Year:	Incident:	Year:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Alcohol consumption: Y / N

If yes, how much and how frequently: _____

Tobacco use: (circle all that apply)

Current / former / never

Smoking / Smokeless

How long: _____ yrs. How much: _____ (packs/day) (tins/day)

Daily water intake (estimated): _____

Do you exercise? Y / N

If yes, please describe type of activity and frequency: _____

_____

Do you have a family history of heart disease, cancer, high blood pressure, diabetes, rheumatologic disorders, or other conditions? Y / N

Relative/relation:	Condition(s):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other signs/ symptoms/ conditions:

Below is a list of other signs, symptoms, and conditions. Please indicate if you have experienced them in the past or are presently experiencing them day to day.

Condition	Past / Present (Circle one)	Condition	Past / present (Circle one)
Shoulder pain	Past / Present	Respiratory condition (COPD, emphysema, etc.…)	Past / Present
Neck pain	Past / Present	High blood pressure	Past / Present
Arm/elbow pain	Past / Present	Digestive Problems	Past / Present
Hand pain	Past / Present	Kidney / bladder problems	Past / Present
Upper back pain	Past / Present	Sinus conditions	Past / Present
Lower back pain	Past / Present	Cancer	Past / Present
Pain in Upper leg or hip	Past / Present	Asthma	Past / Present
Pain in lower leg or knee	Past / Present	Stroke	Past / Present
Pain in ankle/ foot	Past / Present	Unexplained Weight Loss/gain	Past/ Present
Jaw Pain	Past / Present	Skin conditions (rash, bruising, etc…..)	Past / Present
Swelling/ stiffness in joints	Past / Present	Arthritis	Past / Present
Headaches	Past / Present	Diabetes	Past / Present
Dizziness	Past / Present	General prolonged fatigue	Past / Present
Bowel issues (constipation, diarrhea, etc…..)	Past / Present	Night sweats	Past / Present
Numbness/tingling in saddle region	Past / Present	Changes in hearing (tinnitus, loss, etc…..)	Past / present
Changes in Vision (blurred, loss, etc…..)	Past / Present	Changes in sense of taste	Past / Present
Difficulty Swallowing	Past / Present	Shortness of breath	Past / Present
Anemia	Past / Present	Bleeding / Blood disorders (hemophilia, sickle cell disease/trait, etc.…	Past / Present
Depression	Past / Present	Anxiety	Past / Present

By signing below, I verify that the information provided is true and accurate to the best of my knowledge. (Parent/Guardian signature if patient is a minor)

Signature: _____ Date: _____

Frenchtown Chiropractic LLC Privacy Policy and Practices

This notice outlines your rights to access and control your medical information as well as how it may be used and disseminated. Please carefully read it.

Name:_____

Signature:_____ Date:_____

You Rights

You have some rights regarding the information about your health. In order to assist you, this section discusses your rights and some of our obligations.

You are entitled to:

- **Obtain a print or electronic copy of your medical record.**
  - You have the right to request a physical or electronic copy of your medical file as well as any other health information we may hold on you. Ask us for assistance. Within 30 days after receiving your request, we will normally send you a copy or a summary of your health data. We might impose a fair, cost-based fee.
- **Request that we update your medical record.**
  - If you believe that any health information we have on you is inaccurate or lacking, you can request that we change it. Ask us for assistance. If we decline your request, we will give you a written explanation within 60 days.
- **Insist on private correspondence.**
  - We will agree to all reasonable requests from you to contact you with your medical information in a particular way, such as by phone at your home or place of business, or to transmit your medical information to a different address.
- **Request that we limit the amount of information we use or share.**
  - You have the right to request that we not use or disclose specific health information for operations, payment, or treatment. We are not obligated to grant your request, and we have the right to decline if it might jeopardize your care.
  - You have the option to request that we not disclose your information with your health insurance for the purpose of payment or our business operations if you pay in full for a service or healthcare item. Unless a law mandates us to reveal that information, we will respond "yes."
- **Get a list of the people we have shared information with.**
  - For up to six years prior to the date you request it, you have the right to request a list (accounting) of the occasions when we communicated (disclosed) your health information, along with information on who we told and why.
  - All disclosures, with the exception of those pertaining to healthcare operations, payment, and treatment, will be included (such as any you asked us to make). We will

give you one free accounting per year, but if you need another one within a year, we will charge you a fair, cost-based price.

- **Obtain a copy of this privacy statement.**
    - Even though you have consented to receive this notice electronically, you can request a printed copy at any time. We'll send you a paper copy right away.

- **Choose someone to represent you.**
    - Someone can exercise your rights and make decisions regarding your health information if you have granted them medical power of attorney or if they are your legal guardian. Before we do anything, we'll make sure the person has this power and is capable of acting on your behalf.
- **If you believe your rights have been violated, file a complaint.**
    - If you believe we have violated your rights, please get in touch with our privacy officer to file a complaint.
    - Please send your request in writing to the Privacy Officer, Dr. Kevin Pisle, 804 N 2nd St. Saint Charles, MO 63301, 314-341-5860, privacy.officer@frenchtownchiro.com, if you like to make a complaint about our company.
    - You can contact the Office for Civil Rights at the U.S. Department of Health and Human Services by writing to 200 Independence Avenue, SW, Washington, D.C. 20201, calling 877-696-6775, or going online to www.hhs.gov/ocr/privacy/hipaa/complaints/.
    - No adverse actions will be taken against you for filing a complaint.

Your Decisions

You can let us know how you feel about sharing certain health information. Contact us if you have a specific choice for how we share your information in the circumstances listed below. We shall do what you direct as long as you tell us what to do.

In these situations, you have the right to instruct us to:

- Disclose information to members of your family, close friends, or caregivers;
- Disclose information in the event of a disaster
- Enter your details in a hospital directory.

We may share your information if we feel it is in your best interest to do so if you are unable to express your preference, such as if you are incapacitated. When a serious and immediate threat to health or safety exists, we might also release your information.

We never divulge your information in the following circumstances without your express written consent:

- Sale of your protected health information
- Most sharing of psychotherapy notes
- Marketing reasons

In the case of fundraising:

• We may get in touch with you for fundraising purposes, but you can ask us not to. Your wish not to be contacted again will be respected.

Utilizations and Disclosures

The following are typical examples of how we utilize or disclose your health information:

- Treatment
    - We can use your medical information and divulge it to other healthcare providers who are attending to you.
    - Example: A doctor treating you for an injury inquires about another doctor's assessment of your general health.
- Manage our company
    - To manage our practice, enhance your treatment, and get in touch with you when appropriate, we can use and share your health information.
    - Example: We manage your treatment and services using health information about you.
- Submit a service fee invoice.
    - Your health information may be used by us to bill insurance companies or other organizations and collect payment from them.
    - Example: We provide your health insurance plan with information about you so that it will cover services provided to you during the course of your care

How else can we make use of or distribute your health-related data?

Your information may be disclosed to third parties for additional purposes, typically those that advance the public interest, like public health and research, if we have your consent or are required by law to do so. Before we can share your information for these purposes, we must abide by a number of legal requirements.

- **assistance with matters of public health and safety**
    - In certain circumstances, such as:
        - Preventing disease
        - Aiding in product recalls
        - Reporting adverse medication ractions
        - Reporting suspected child abuse, elder abuse, or domestic violence
        - Preventing or lessening a major threat to anyone's health or safety.
- **Conduct research**
    - Your information may be shared or used by us for health research.
- **Follow the law.**
    - If state or federal laws require it, we will share information about you, including with the Department of Health and Human Services if it needs to verify that we are abiding by federal privacy legislation.
- **Work with a funeral director or medical examiner**

    - When someone passes away, we can give a coroner, medical examiner, or funeral director access to health records.
- **Regarding police enforcement, workers' compensation, and other government requests**
    - We may make use of or divulge health data about you if:
        - With health monitoring organizations for operations permitted by law, for workers' compensation claims, for law enforcement purposes, with a law enforcement official, and for particular government tasks such military, national security, and presidential protective services.
- **Reply to court orders and legal actions**
    - In response to a subpoena, court order, or administrative directive, we may divulge medical data about you.

Our Obligations

- We must follow legal requirements to protect the privacy and security of your protected health information, and we'll let you know right away if there's a breach that would have jeopardized those protections.
- We must abide by the obligations and privacy policies outlined in this notice and provide you with a copy of it.
- We won't use or share your information in any other way unless you give us written consent to do so. You are free to alter your mind at any moment if you tell us we can. If you change your mind, please let us know in writing.

Modifications to the Notice's Conditions

We reserve the right to modify this notice at any time, and any updated terms will be applicable to all of your personal data. On request, a copy of the new notice will be mailed to you and available online and on our website.

Effective Date of the Policy: 1/24/2023