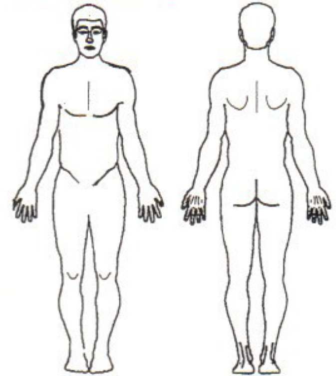
Initial Health Status

Patient Name:______________________________ Birthdate:______________ Sex: M / F
Address:______________________ City:________________ State:________ Zip:_______
Home Phone:______________ Cell Phone:________________ Work Phone:______________
Occupation:__________________________ Employer:__________________________
Work Address:____________________ City:________________ State:________ Zip:_______
Spouse Name:____________________
Does your Health Plan offer Chiropractic Benefits: YES / NO / Not Sure
If YES: Health Plan: ________________________ Subscriber ID:________________

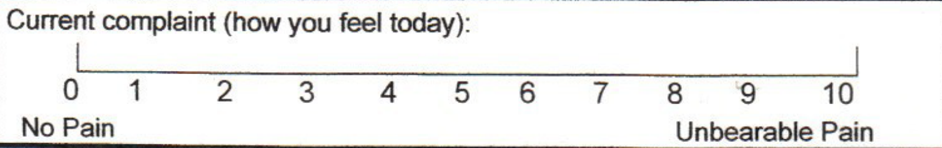
MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain
☐ Other____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began:______________________________
How Problem Began: ______________________________

Current complaint (how you feel today):



How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%
Can you perform your daily activities? ☐ Yes ☐ No (Describe any current activity limitations) ______________

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** ______________
WHAT AREAS WERE TAKEN?______________________________

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Currently Pregnant, # weeks________
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	Low/Mid Back Pain
☐	☐	Stroke (date) ______________	☐	☐	Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Nocturnal Pain (pain at night)
☐	☐	Cancer/Tumor	☐	☐	Surgeries______________
☐	☐	Osteoporosis			
☐	☐	Recent Trauma	☐	☐	Medications:______________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ______________________ **Date:** ______________________

Email:____

Ohana Chiropractic LLC
34970 Detroit Rd. Suit 212
Avon, Ohio 44011

Phone: 440-695-8121
Fax: 440-695-0068

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow 'Ohana Chiropractic Center to submit requested PHI to the Health Insurance Company/s provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of PHI to the minimum needed for what the insurance companies require for payment. This office will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.
- The patient has a right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request, but would apply to any care given after the request has been presented.
- 'Ohana Chiropractic Center may use your information to provide appointment reminders, information about treatment alternatives or other health related issues.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those policies in our office.
- You may file a formal complaint with our Privacy Officer about any possible violations of these policies and procedures. You will not be retaliated against for filing a complaint.
- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

________________________________ Patient Name

Date ____________________________

________________________________ Patient Signature or Legal Guardian