POULSBO VILLAGE CHIROPRACTIC OFFICE

JAMES T. RYAN, D.C.
Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST!

PATIENT INFORMATION **Today's Date:**

Name:_____ Date Of Birth:_____
Mailing Address: _____City:_____State:____Zip:_____
Best contact phone:_____
Additional phone:_____
Email:_____ Age:_____ ☐ Male ☐Female
Name of Spouse or Nearest Relative:_____ Phone:_____
Your Occupation:_____ Employer:_____
Referred by: ☐Doctor/Family/Friend member – Name?_____
☐Yellow Pages ☐Mailing ☐Location (drove by) ☐Other_____
Payment For Services Will Be By: ☐Cash/Check ☐Mastercard/Visa
☐Health Insurance ☐Auto Insurance/PIP Claim ☐Worker's Compensation

MEDICAL/FAMILY HISTORY **S=Self** **M=Mother** **F=Father**
(Please indicate which PAST conditions have been experienced prior to present complaint by marking the appropriate boxes)

S	M	F		S	M	F	
☐	☐	☐	Anemia	☐	☐	☐	Heart trouble
☐	☐	☐	Asthma	☐	☐	☐	High blood pressure
☐	☐	☐	Back pain	☐	☐	☐	Indigestion
☐	☐	☐	Bladder control	☐	☐	☐	Menstrual cramps
☐	☐	☐	Bone fracture	☐	☐	☐	Multiple sclerosis
☐	☐	☐	Cancer	☐	☐	☐	Neck pain
☐	☐	☐	Chest pain	☐	☐	☐	Nervousness
☐	☐	☐	Concussion	☐	☐	☐	Numbness
☐	☐	☐	Diabetes	☐	☐	☐	Polio
☐	☐	☐	Dislocated joints	☐	☐	☐	Poor circulation
☐	☐	☐	Epilepsy	☐	☐	☐	Rheumatic fever
☐	☐	☐	Headaches	☐	☐	☐	Sinus trouble

Have you been treated by a physician for any health condition in the past year? ☐Yes ☐No
Describe Condition:_____ Date of last physical exam:_____
Do you have a Primary Care Physician? ☐Yes ☐No Name & location:_____
Surgical History:
1. _____ Year:_____
2. _____ Year:_____
3. _____ Year:_____

Accident History: ☐Job ☐Auto ☐Other 1._____Mo/Yr_____
Including falls ☐Job ☐Auto ☐Other 2._____Mo/Yr_____
☐Job ☐Auto ☐Other 3._____Mo/Yr_____

Are you pregnant? ☐No ☐Yes Date of last Menstrual Period:_____
Are you allergic to any medications? ☐No ☐Yes-_____
Are you taking any medications? ☐No ☐Yes-_____

☐ Too many to list

PLEASE DESCRIBE YOUR PRESENT MAJOR COMPLAINTS:

Please rate your symptoms 1-10 (1 being least serious)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Symptoms are worse in: ☐Morning ☐Afternoon ☐Night

When & How Occurred: _____

_____

_____

Symptoms Developed From: ☐Job Related Injury ☐Auto Accident
☐Accident ☐Illness ☐Other ☐Unknown Cause ☐Gradual Onset
Date Occurred: _____

Symptoms Have Persisted For: #____Hours ____Days ____Weeks ____Months ____Years

Symptoms/Complaints: ☐Come & Go ☐Are Constant

Have you ever had this before? ☐Yes ☐No When?_____

If you were to guess, what do you think is causing your complaints? _____

_____

Name & location of Doctors previously seen for this condition: _____

_____

Please Check All Activities That ***Aggravate*** Your Condition: ☐Bending ☐Lifting
☐Reaching ☐Sneezing ☐Walking ☐Coughing ☐Sitting ☐Standing
☐Turning Head ☐Lying Down ☐Straining at Stool

Please Check All Activities That ***Relieve*** Your Condition: ☐Bending ☐Lifting
☐Reaching ☐Walking ☐Sitting ☐Standing ☐Lying Down ☐Turning head

Please Check Any Additional Symptoms You May Be Experiencing:

☐blurred vision	☐buzzing in ears	☐cold hands/feet	☐cold sweats	☐constipation
☐concentration loss	☐depression	☐diarrhea	☐dizziness	☐flushed face
☐fainting	☐fatigue	☐head seems heavy	☐fever	☐headaches
☐insomnia	☐light sensitivity	☐loss of balance	☐loss of smell	☐loss of taste
☐low immunity	☐muscle jerking	☐numbness in fingers	☐numbness in toes	
☐pins & needles–legs	☐pins & needles-arms	☐ringing in ears	☐shortness of breath	
☐stiff neck	☐stomach upset			

OFFICE POLICY:

♥Professional care is given to you, our patient, not to an insurance company. Thus, the insurance company is responsible to the patient and the patient to the doctor. As a courtesy to you, we will bill your insurance and help in any way we can to get your claims taken care of. Health insurance plans often cover portions of chiropractic. Please be sure to examine your insurance plan carefully. We will not allow an account to reach an amount over $200.00 without some form of payment.

♥Appointments that cannot be kept must be rescheduled or cancelled 24 hours in advance to avoid a missed appointment charge.

Signature (patient or guardian)_____Date_____

HIPAA NOTICE of PRIVACY PRACTICES
POULSBO VILLAGE CHIROPRACTIC OFFICE
19425 7TH Ave. Suite 103
Poulsbo, WA 98370

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 may relate to your past, present, or future physical or mental health condition and any related health care services.

Uses and Discloses 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 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 to you, or 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. 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. We may disclose your protected health information to medical school students that see patients in 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 you physician is ready to see you. We may use or disclose your protected health information, as necessary, in order to contact you for appointment reminders.

We may use or disclose your protected health information in the following situations without your authorization. The situations include, As Required by Law, Public Health issues, Communicable Diseases, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers Compensation, and Inmates Required Uses and Disclosures. We must make disclosures to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization opportunity to object unless required by law.

(Over)

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 disclose indicated in the authorization.

Your Rights: Following is a statement of 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, or any 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 of the purposes of treatment, payment or health care 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 the Notice of Privacy Practices. Your request must state the 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 the physician believes it is in your best interest to permit use and disclose of your protected health information your protected health information will not be restricted. You then 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 physician 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.

You 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 the 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 we have violated your privacy rights 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 after, 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 Privacy Practices.

Print Name: _____ Signature: _____ Date: _____

PATIENT NAME:_____ DATE_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D= Dull	S= Stabbing
B= Burning	T= Tingling (pins & needles)
N= Numb	C= Cramping