PEAK
HEALTH CENTER

APPLICATION FOR CHIROPRACTIC CARE AT PEAK HEALTH CENTER

Today's Date: _____ HRN:_____

PATIENT DEMOGRAPHICS

Name: _____ DOB:_____ Age: _____ ☐ Male ☐ Female

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

Email Address: _____ Home Phone: _____ Cell: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance? ☐ Yes ☐ No

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 that brought you to the office. Primarily: _____

Secondarily: _____ Third: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number:

Primary Complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second Complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third Complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at it's worst? ☐ AM ☐ PM

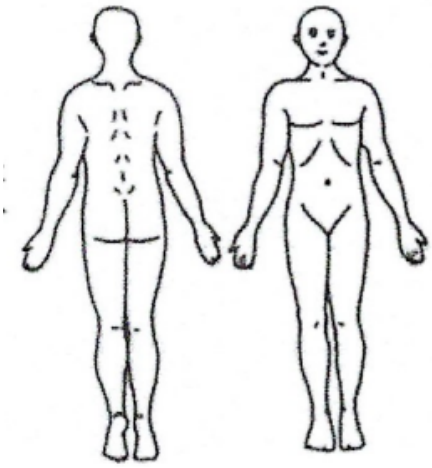
How long does it last? ☐ It is constant ☐ On and off during the day ☐ Comes and goes during the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? If yes, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of previous Chiropractor if applicable: _____



Please mark the areas on the Diagram with the following letters to describe your symptoms: **R** = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of ANY type of accident? ☐

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

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes If yes, how many times? _____
How did the injury happen? _____

Other forms of treatment tried? ☐ No ☐ Yes If yes, what type of treatment? _____

Who provided it? _____ Were the results ☐ favorable ☐ unfavorable

Please explain: _____

Please identify any and all types of jobs you have had that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the *Past*, C for *Currently* have, and N for *Never* have had:

___ Broken Bone ___ Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer

___ Heart Attack ___Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions:

Please identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem.

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

SOCIAL HISTORY

1. Smoking ☐ Cigars ☐ Pipe ☐ Cigarettes — How Often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcohol Consumption — ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug Use — ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same conditions? ☐ No ☐ Yes
   a. If Yes, whom?: ☐ grandmother ☐ grandfather ☐ father ☐ sister ☐ brother ☐ son ☐ daughter
   b. Have they been treated for their condition? ☐ no ☐ yes ☐ I don't know
   c. Any other hereditary conditions the Doctor should be aware of? _____

I hereby authorize payment to be made directly to **Peak Health Center** 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 Peak Health Center for any and all services I receive at this office.

_____ _____

Patient or Authorized Person's Signature — Date Completed

_____ _____

Doctor's Signature — Date Completed

Patient's Name: _____ HR#:_____

ACTIVITIES OF DAILY LIVING: Please identify how your current condition is affecting your ability to carry out activities that are routinely a part of your life:

Bending	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Computer Work	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activity	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Running/Walking	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform

Please mark **P** for in the **Past**, **C** for **Currently experiencing**, and **N** for **Never**

___ Headache	___Pregnant	___ Dizziness	___Prostate Problems	___Ulcers
___Neck Pain	___ Frequent Colds	___Loss of Balance	___Impotence/Sexual Dysfunc.	___Heartburn
___Jaw Pain, TMJ	___Epilepsy	___Fainting	___Digestive Issues	___Tremors
___Shoulder Pain	___Heart Problems	___Double Vision	___Colon Trouble	___PMS
___Low Blood Pressure	___High Blood Pressure	___Mid Back Pain	___Upper Back Pain	___Hearing Loss
___Low Back Pain	___Diarrhea	___Constipation	___Depression	___Asthma
___Liver Trouble	___Sinus Problems	___Menstrual Problems	___Menopausal Problems	___Scoliosis
___Foot or Knee Issues	___Skin Problems	___Learning Disability	___Eating Disorder	___Allergies
___Hepatitis (A, B, C)	___Insomnia	___Swollen Joints	___Mood Changes	___ADD/ADHD
___Difficulty Breathing	___Lung Problems	___Kidney Problems	___Gallbladder Problems	___Liver Issues
___Eating Disorder	___Back Curvature	___Bed Wetting	___Numbness in extremities	___Irritable

Please list any prescription or over-the-counter drugs you take: _____

_____

_____

Peak Health Center NOTICE OF PRIVACY

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. 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 circumstances. Once you have signed the last page, keep this page for your records.

Permitted Disclosures:

1. Treatment purposes - discussion with other health care providers in your care
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to our Doctor(s), please let our staff know so that you can be placed in a private consultation room.
3. Payment Purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation
5. Emergency - we may notify a family member
6. For public health and safety - to prevent or lessen a serious or imminent threat to the health or safety of a person or the general public.
7. To Government agencies or Law Enforcement - to identify a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes
9. Deceased persons - with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails with appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your Personal Health Information

Your Rights:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive 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.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance (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.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.

Complaints:

If you wish to file a formal complaint about how we handle your health information, please call Maryjane LaDue at 919-369-0771. If she is unavailable, you may make an appointment to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you may submit a written complaint to:

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

Peak Health Center NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Peak Health Center'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 any 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. At this time, I do not have any questions regarding my rights or any information I have received.

_____	_____	_____
Patient's Name	DOB	HR#

_____	_____
Patient's Signature	Date