

## **Cherry Street Chiropractic**

### **CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE**

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This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Service Representative assist you.

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status: \_\_\_M\_\_\_S\_\_\_D\_\_\_W Drivers License #: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Your Email Address: \_\_\_\_\_

IS YOUR VISIT DUE TO AN ACCIDENT: \_\_\_\_\_YES \_\_\_\_\_NO

Are you a Medicare Participant? \_\_\_\_\_YES \_\_\_\_\_NO

Your Spouse's Name: \_\_\_\_\_

Name of person to contact in case of emergency: \_\_\_\_\_

Their home and work phone numbers: \_\_\_\_\_

Who referred you to this office so we may thank them? \_\_\_\_\_

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement or settlement.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Insurance Coverage Information

### Medical Insurance:

Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_

### Workers Compensation Injury:

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Was injury/accident reported to supervisor? Y/N Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Workers Comp Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Carriers Phone: \_\_\_\_\_ Adjuster: \_\_\_\_\_  
Claim Number: \_\_\_\_\_

### Auto/Personal Injury:

Do you have "Med Pay" on your Auto Policy: Yes / No Amount: \$ \_\_\_\_\_  
Insurance Carrier Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Adjuster: \_\_\_\_\_ Claim Number: \_\_\_\_\_

### Third Party Payer (other involved vehicle insurance)

Third Party ( Person at Fault's ) Name: \_\_\_\_\_ Ph: \_\_\_\_\_  
THEIR Insurance Carrier: \_\_\_\_\_ Ph: \_\_\_\_\_  
Address: \_\_\_\_\_  
Adjuster: \_\_\_\_\_ Claim Number: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Present Complaints and Concerns (Please check appropriate boxes.)

### Weight Concerns:

- Underweight
- Overweight by <10 lbs/20 lbs/40 lbs/60 lbs/80 lbs/100 lbs
- I have no concerns about my weight.

### Health Concerns:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headache             | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Loss of Smell                |
| <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Shortness of Breath          |
| <input type="checkbox"/> Neck Stiffness       | <input type="checkbox"/> Poor Balance         | <input type="checkbox"/> Chest Pain                   |
| <input type="checkbox"/> Neck Restriction     | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Constipation                 |
| <input type="checkbox"/> Upper Back Pain      | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Diarrhea                     |
| <input type="checkbox"/> Upper Back Stiffness | <input type="checkbox"/> Depression           | <input type="checkbox"/> Cold Hands/Feet              |
| <input type="checkbox"/> Midback Pain         | <input type="checkbox"/> Fear                 | <input type="checkbox"/> Unexplained Weight Loss/Gain |
| <input type="checkbox"/> Midback Stiffness    | <input type="checkbox"/> Confusion            | <input type="checkbox"/> Pin/Needles in Arms (R/L)    |
| <input type="checkbox"/> Low Back Pain        | <input type="checkbox"/> Head Seems Heavy     | <input type="checkbox"/> Pins/Needles in Hands (R/L)  |
| <input type="checkbox"/> Low Back Stiffness   | <input type="checkbox"/> Eye Strain/Pain      | <input type="checkbox"/> Pins/Needles in Legs (R/L)   |
| <input type="checkbox"/> Rib Pain             | <input type="checkbox"/> Blurred Vision       |   |
| <input type="checkbox"/> Tension              | <input type="checkbox"/> Double Vision        |   |
| <input type="checkbox"/> Mental Dullness      | <input type="checkbox"/> Ringing/Buzzing Ears |   |
| <input type="checkbox"/> Loss of Memory       | <input type="checkbox"/> Loss of Taste        |   |

### Difficulty with:

- Standing
- Sitting
- Bending
- Walking

### Radiating Pain:

- Right Arm
- Left Arm
- Right Leg
- Left Leg
- Neck
- Base of Skull
- Ribs
- Shoulder (R/L)

### Difficulty lifting:

- Light
- Moderate
- Heavy
- Repetitive

### Extremity Pain:

- Foot (R/L)
- Ankle (R/L)
- Knee (R/L)
- Hip (R/L)
- Shoulder (R/L)
- Elbow (R/L)
- Wrist (R/L)
- Hand (R/L)

**OTHER CONCERNS:** \_\_\_\_\_

Since the time this (these) complaint(s) began, what, if anything, have you tried that **DID NOT** work?  
\_\_\_\_\_

Has the problem interrupted your sleep? Yes / No How: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Present Complaints and Concerns (continued)

Please list any doctors or therapists that you have seen for this complaint:

1. \_\_\_\_\_ Specialty \_\_\_\_\_
2. \_\_\_\_\_ Specialty \_\_\_\_\_
3. \_\_\_\_\_ Specialty \_\_\_\_\_

Relevant Medical History: (Please circle the conditions you have or had previously)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Neck Pain/Spasms   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Hand or Wrist Pain  | <input type="checkbox"/> Neuritis           |
| <input type="checkbox"/> Back Pain/Spasms   | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Concussion         | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Convulsion         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems     |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Sciatica           |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Measles             | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Venereal Diseases  |

Does anyone in your family have similar health related problems? Yes / No

Who: \_\_\_\_\_

Condition: \_\_\_\_\_

Type of Care Received: \_\_\_\_\_

Is the Care Helpful? Yes / No

May we contact them regarding their condition? Yes / No

Please list any operations that you have had and approximate dates:

1. \_\_\_\_\_ Date: \_\_\_\_\_ Dr: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_ Dr: \_\_\_\_\_
3. \_\_\_\_\_ Date: \_\_\_\_\_ Dr: \_\_\_\_\_
4. \_\_\_\_\_ Date: \_\_\_\_\_ Dr: \_\_\_\_\_

Are you allergic to any medications? Please List: \_\_\_\_\_

Are you taking any medications? Please List: \_\_\_\_\_

Do you wear orthotics (shoe inserts)? Yes / No If yes, what type? \_\_\_\_\_

Are you pregnant: Yes / No If yes, due date: \_\_\_\_\_

Do you: Smoke: Yes / No Amount per day: \_\_\_\_\_

Drink: Yes / No \_\_\_\_\_ Light \_\_\_\_\_ Medium \_\_\_\_\_ Heavy

Exercise: \_\_\_\_\_ Never \_\_\_\_\_ Sometimes \_\_\_\_\_ Frequently \_\_\_\_\_ Regularly

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.**

**Please check the type of care desired so that we may be guided by your wishes whenever possible.**

✧ **Relief Care**

✧ **Corrective Care**

✧ **I would like the Doctor to select the type of care appropriate for my condition**

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**Relief Care**

Relief Care is the care necessary to get rid of your symptoms or pain but not the cause of it. It is the same as drying a floor that was getting wet from a leak without fixing the leak.



**Corrective Care**

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is more lasting.

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees from professional services rendered me will be immediately due and payable.*

*I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. The x-rays will remain on file where they may be seen at any time while a patient of this office. The patient agrees that he or she is responsible for all bills incurred at this office.*

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Consent to Treat a Minor** \_\_\_\_\_ **Date** \_\_\_\_\_

**Guardian/Spouse Signature to Authorize Care** \_\_\_\_\_ **Date** \_\_\_\_\_

## Notice of Privacy Practices

**Cherry Street Chiropractic Clinic  
1825 East 15<sup>th</sup> Street  
Tulsa, OK 74104  
(918) 712-2220**

**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**

### What is Protected Health Information (PHI)?

Our practice values your privacy and is committed to protecting medical information about you. Protected Health Information, or “PHI,” is ANY HEALTH INFORMATION that can be used to identify you, which we maintain or transmit in written, oral, or electronic form. It may relate to your past, present, or future medical health or services.

This Notice of Privacy Practices tell you how we may use and disclose, your PHI that deals with your Treatment, Payment, or Health Care Operations (TPO), or for other lawful purposes.

It also describes your rights under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191).

This notice is EFFECTIVE April 14, 2003

We will abide by all terms of this notice as required by HIPPA including our right to charge the terms of this notice, at any time. Any changes will be effective for your entire PHI that we maintain at the time of the change. We will prominently post any notice of changes in our office lobby and on our web site for your review. You may also request a revised notice by calling or writing our office.

## Summary of Privacy Practices

This document describes how we safeguard your Protected Health Information (PHI) to make sure only the minimum amount of information is used and disclosed only to individuals with a legal right to access or view your PHI.

Use is the sharing, utilization, or examination of information by individuals within our practice.

Disclosure is the release, transfer, or divulging of information by us to individuals, outside our practice.

Consent is your granting us permission to disclose your PHI in order to provide you treatment, provide for payment of your health services, or manage our health care operations.

Authorization is when you give us written permission to release your information to you, another person, or an organization.

### **This document tells you the circumstances in which we can use or disclose your PHI.**

**1. With Your Written Consent**

Your personal health information will be used by staff or other health care professionals to offer treatment.

**2. With Your Written Authorization**

Your personal health information will be disclosed to another professional organization (health care facility, insurance company) to assist us in providing payment for services.

**3. With or Without Your Consent or Authorization**

If any county, state, or federal law requires that we use or disclose your personal health information by court order. If the law requires such action we will notify you of such disclosure.

**4. Your Rights**

Your rights regarding your personal health information are listed in full in the full document located in this facility. You may access information at any time. You have the right to request that we not use or disclose any, or part of, your personal health information.

**5. Complaints**

You have the right to complain to us if you believe your privacy rights have been violated by us. Any complaints should be in writing and state the nature of the complaint and how you may be contacted. These complaints should be directed to the privacy officer listed below.

**Privacy Officer Contact Information:**

**Jill Pray**

**Cherry Street Chiropractic and Wellness Center**

**1825 East 15<sup>th</sup> Street**

**Tulsa, OK 74104**

**(918) 712-2220**

**Acknowledgment of Receipt of  
Notice of Privacy Practices**

**Cherry Street Chiropractic and  
Wellness Center  
1825 East 15<sup>th</sup> Street  
Tulsa, OK 74104  
(918) 712-2220**

I \_\_\_\_\_ acknowledge that I have received a copy of the  
Notice of Privacy Practices of **Cherry Street Chiropractic and Wellness Center**, and a copy of  
this acknowledgment.

If you have any questions, please contact the privacy officer whose name and contact  
information is listed below.

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**Name of Patient or Personal Representative (Printed)**

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**Signature of Patient or Personal Representative**

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**Date**

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**Personal Representative's Relationship or Authority**

**Privacy Officer:**

**Jill Pray  
Cherry Street Chiropractic  
1825 East 15<sup>th</sup> Street  
Tulsa, OK 74104  
(918) 712-2220**

## Authorization To Release Information

This form is for us to be able to request any other medical records from another facility that you have been seen at for the same condition that we are seeing you for.

I, \_\_\_\_\_ hereby authorize:  
(Name of Patient) (Date of Birth) (Social Security #)

\_\_\_\_\_, \_\_\_\_\_  
(Name) (Address)

to release the following information to:

\_\_\_\_\_, \_\_\_\_\_  
(Name) (Address)

Please check all that apply:

- Any information contained in the clinical record of the above patient regarding treatment or other care.
- The information contained in the clinical record of the above patient for the period from \_\_\_\_\_ to \_\_\_\_\_.
- The information contained in the complete clinical record of the above patient.
- Other \_\_\_\_\_

For the following purpose: \_\_\_\_\_

This consent will expire on \_\_\_\_\_ or 6 months after the date of signature. I understand this authorization subject to revocation by me at any time except to the extent that action has already been taken reliance on it. A copy of this authorization will be valid.

I understand that my medical records may contain information that indicates that I have a communicable or venereal disease, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, or human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).

With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity and release medical group, its agents and employees from any liability in connection with the release of the information contained therein.

\_\_\_\_\_  
(Signature of Patient) (Date) (Signature of Witness)

\_\_\_\_\_  
(Signature of Parent, Guardian, or Legal Representative) (Nature of relationship to Patient)

\_\_\_\_\_  
(Reason patient is unable to sign)