Hollenbach
Family Chiropractic
Creating a Healthy Lifestyle

DX:_____

PERSONAL HEALTH HISTORY

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Referred by: _____ Email address: _____

Marital Status: _____ Phone #: Home/Cell _____

Name of Employer: _____ Occupation: _____

Children's Names and Ages: _____

Hobbies: _____ Primary Care Provider: _____

Name of previous Chiropractor(s): _____

When was your last visit? _____

How long were you receiving Chiropractic treatment? _____

Reason for coming in (chief complaint): _____

Are you pregnant? _____If yes, how many weeks: _____ Due Date: _____ OBGYN / Midwife: _____

Would you be interested in:

Acupuncture ☐ Massage Therapy ☐ Naturopathy ☐ Nutrition Counseling ☐ Orthotics ☐ Thermography ☐

What accidents have you had? (i.e. car, sports, slips/falls) at work or at home (*include dates*): _____

Were you ever knocked unconscious? _____

What fractures or broken bones have you had? (*include dates*): _____

_____

Surgery: What major surgery have you had? (*include dates*): _____

_____

What minor surgery have you had? (tonsillectomy, wart/cyst removal, dental extraction) (*include dates*): _____

_____

Medication:

Present Prescription Medication	Past Prescription Medication	Over-the-counter Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Health

Please use the following to answer questions below: Poor, Good or Excellent

How would you describe your current health? _____

How would you describe your family's health? _____

Describe your: Vision _____ Hearing _____ Coordination _____

How would you describe your sleep? _____

Level of stress in your life: Mild ☐ Moderate ☐ Extreme ☐ 1 2 3 4 5 6 7 8 9 10

Work Stress? _____ Home/Family Stress? _____

How would you describe your diet? _____

Financial Information (Insurance Only)

Who is responsible for this account? _____

Name of Insurance Company: _____ Policy No: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY OR YOU HAVE HAD RECENTLY

1	2	3	4
A___ Headaches	A___ Fainting	A___ Shortness of Breath	
B___ Shooting head pain	B___ Loss of balance	B___ Mid-back pain	A___ Numbness-legs/feet
C___ Sinus Trouble	C___ Ringing in ears	C___ Heart Attack	B___ Constipation
D___ Loss of smell	D___ Blurred vision	D___ Low blood pressure	C___ Kidney trouble
E___ Allergies	E___ Lights bother your eyes	E___ High blood pressure	D___ Menstrual cramps/pain
F___ Hay Fever	F___ Neck pain	F___ Anemia	E___ Menstrual irregularity
G___ Asthma	G___ Neck muscle spasm	G___ Stomach trouble	F___ Diabetes
H___ Loss of taste	H___ Grinding in neck	H___ Nervousness	G___ Sleeping problems
I___ Inflammation of throat	I___ Shoulder/arm tightness	I___ Inner tension	H___ Painful joints
J___ Thyroid trouble	J___ Shoulder/arm pain	J___ Irritability	I___ Swollen joints
K___ Facial Twitch	K___ Pins & needles in arms	K___ Gall bladder trouble	J___ Pins & needles in legs
L___ Loss of memory	L___ Pins & needles in hands	L___ Indigestion	K___ Swollen ankles
M___ Fatigue	M___ Cold hands	M___ Intestinal gas	L___ Cold feet
N___ Depression	N___ Numbness – arms/hands	N___ Low back pain	M___ Pain in legs/feet
O___ Dizziness	O___ Swollen tonsils	O___ Hernia	N___ Hip pain
P___ Spinal curvature	P___ Prostate trouble	P___ Stroke	O___ Facial pain
Q___ Chest pain	Q___ Bed wetting	Q___ Arthritis	P___ Jaw pain (TMJ)
R___ Earache	R___ Cancer	R___ Sciatica	Q___ Ulcers

Office use: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

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TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has one important goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of HOLLENBACH FAMILY CHIROPRACTIC to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my health.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____ have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child (under 18 yoa):
I, _____, being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

_____ _____
Parent or Legal Guardian's Signature Date

NOTICE OF PRIVACY PRACTICES
FOR PROTECED HEALTH INFORMATION

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include a physician examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payments.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointments reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

To have the following rights with respect to your health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information. Including those related to disclosures to family members, other relatives, close personal friends, or any person identified by you. We are however, not required to agree to a request restriction. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquires, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257/Toll Free: 1-877-696-6775

I, _____ have read and understand these guidelines above.

Patient Signature: _____

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the Federal policy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Hollenbach.

This notice is effective as of _____. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Please Print)	Signature	Date

If you are a minor or if you are being represented by another party:

_____	_____	_____
Personal Representative Name	Personal Representative Signature	Date

_____
Description of the authority to act on behalf of the patient.