HEALTHROCK
CHIROPRACTIC SPORTS MEDICINE

Patient General Information Questionnaire

Thank you for visiting our office today! We are committed to serve our community in a professional clinical environment and to empower our patients to actively take in charge of their own health. In our office, we recognize and respect our body as a self-developing, self-maintaining, and self-healing living organism. We rely on accurate information you provide to us, please take a moment to fill out this form which will assure us to better assist you.

If you have been involved in an auto accident or a work injury please speak to one of the office assistants before you fill out this form.

First Name _____ **Last Name** _____ **M.I** _____

Prefer to be called _____ **Date of Birth** _____ **[ ] M [ ] F**

Patient or Guardian's Name (if patient is a Minor) _____

Mailing Address: _____

City: _____ **State:** _____ **Post Code:** _____

Home phone: _____**Mobile:** _____**Work:** _____

Email: _____

Occupation: _____

Are you currently pregnant? [ ] Yes [ ] No [ ] Maybe [ ] N/A

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Emergency Contact Person: _____ Relationship: [ ]Spouse [ ]Parent [ ]Friend/other

Emergency Contact Number: _____

Do not write below this line

Are You here for specific condition? [ ] Yes [ ] No **If No, please go directly to next page.**

Chief Complaint 1:

- **Briefly describe your complaint:** _____
- **Pain scale:** (best) 0 1 2 3 4 5 6 7 8 9 10 (worst)
- **Types of pain**

[ ]Sharp [ ] Dull [ ]Ache [ ]Sore [ ]Numbness/Tingling
[ ]Pinching [ ]Tightness/Spasm [ ] Burning

- **It is** [ ] Constant [ ] Comes & Goes **How long have you had this problem:**_____

It is better in: [ ] Morning [ ] Afternoon [ ] Evening

- **Check all that aggravate your condition:**

[ ] Driving [ ] Walking [ ] Sitting [ ] Exercising [ ] Standing
[ ] Bending [ ] coughing [ ] breathing [ ] Bowel movements
[ ]Other: _____

- **Check all that make your condition better:**

[ ] Resting [ ] Stretching [ ] Sitting [ ] Standing [ ] Exercising [ ] Massage
[ ] Chiropractic [ ] Medication [ ] Recumbent [ ] Nothing
[ ]Other: _____

- **Have you had this condition before?** [ ]Yes [ ] No If Yes, When:_____
- **Have you seen any other healthcare provider for your current condition?** [ ] Yes [ ] No

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Chief Complaint 2:

- **Briefly describe your complaint:** _____
- **Pain scale:** (best) 0 1 2 3 4 5 6 7 8 9 10 (worst)
- **What kind of pain**

[ ]Sharp [ ] Dull [ ]Ache [ ]Sore [ ]Numbness/Tingling
[ ]Pinching [ ]Tightness/Spasm [ ] Burning

- **It is** [ ] Constant [ ] Comes & Goes **How long have you had this problem**_____

It is better in: [ ] Morning [ ] Afternoon [ ] Evening

- **Check all that aggravate your condition:**

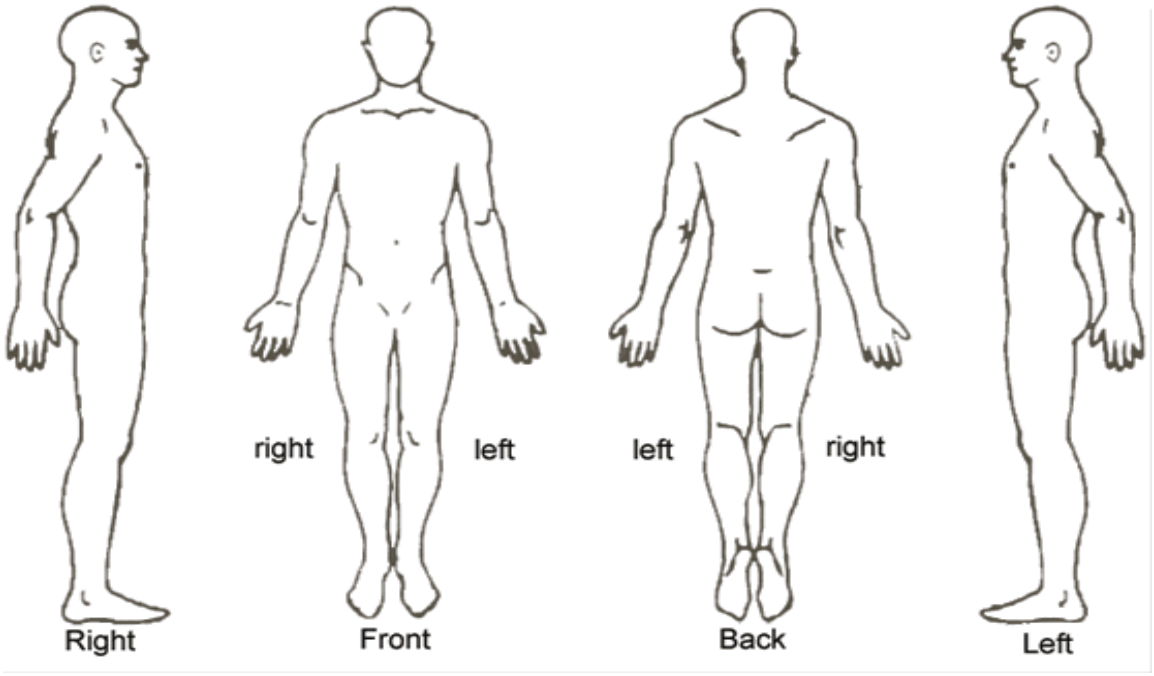
[ ] Driving [ ] Walking [ ] Sitting [ ] Exercising [ ] Standing
[ ] Bending [ ] coughing [ ] breathing [ ] Bowel movements
[ ]Other: _____

- **Check all that make your condition better:**

[ ] Resting [ ] Stretching [ ] Sitting [ ] Standing [ ] Exercising [ ] Massage
[ ] Chiropractic [ ] Medication [ ] Recumbent [ ] Nothing
[ ]Other: _____

- **Have you had this condition before?** [ ]Yes [ ] No If Yes, When:_____
- **Have you seen any other healthcare provider for your current condition?** [ ] Yes [ ] No

Please mark the areas of your conditions



S= Sharp, N= Numb, P= Pinch, B= Burning, A= Ache

Review of Systems

Please mark <u>all</u> conditions that you have currently or have had in the past.

C= Current ***P= Past*** ***If None of the following apply, please check here. [ ]***

Muscle/Joint	**ERT/Internal/Dig-estive**	**Cardiovascular** C P	**Pulmonary** C P	**General**
Arthritis C P	Thyroid C P	Blood Pressure C P	C.O.P.D. C P	Food Allergy C P
Back Pain C P	Hearing C P	Irregular HR C P	Asthma C P	Dizziness C P
Sciatic Pain C P	Vision C P	Poor Circulation C P	Seasonal Allergy C P	**Infectious Disease**
Hip Pain C P	Ear Infection C P	**Urinary/Reproductive**	**Skin**	HIV C P
Foot Pain C P	Stomach C P	UTI C P	Psoriasis C P	Hepatitis C P
Neck Pain C P	Intestinal C P	Prostate C P	Varicose C P	TB C P
Headache C P	Colon C P	Kidney C P	Skin Allergy C P	**Endocrine** C P
Shoulder Pain C P	Liver C P	Pregnancy C P	Hives C P	**Neurological** C P
Arm Pain C P	Gall Bladder C P	Menstrual C P	Easy Bruising C P	**Psychological** C P
Wrist Pain C P	Pancreas C P	Venereal Disease C P		
		Difficulty Urinating C P		

Are You Taking any Medications and Supplements? If Yes please list:

_____

_____

Past Health History:

- Accidents, Injuries, Fractures (Dates) _____

_____

- Hospitalizations, Surgeries (Dates)

_____

_____

Family History of any health conditions:

_____

_____

Life Style:

- Do you drink? [ ] Yes [ ] No. If YES, How many glasses per day or per week? _____
- Do you smoke or using any tobacco product?
  [ ] Yes [ ]NO, If YES, how many packs per day or per week? _____
- Do you exercise? [ ] Yes [ ] No If YES, How many times a week?_____
- Type of exercise ***(circle ones that apply)***
  Stretching/ Flexibility Running/ Treadmill/ Walking Swimming/ Rowing
  Competitive athlete Pilates/ Yoga Weight Lifting Triathlon others:_____
- Sleep hours and Quality: _____ hours/ day, **Excellent Good Fair Poor** *(circle one)*
- ***Do you have any specific physical/functional goal(s) that you'd like to accomplish***

_____

_____

_____

_____

Consent for Chiropractic Care in HealthRock Chiropractic & Sports Medicine

Chiropractic care is based on clinical evidence of vertebral subluxations and not the presence or absence of pain, abnormal rang of motion, or abnormal spinal curves. By the use of specific analysis and spinal and/or extremity adjustments, the goal of chiropractic is primarily to reduce/correct spinal subluxations.

- *In some situations, your care will occur in an open environment and personal health information (PHI) may be subject to incidental exposure by others in the clinic setting. I understand and consent to be treated in such environment.*
- *I authorize **HealthRock Chiropractic & Sports Medicine** and its agents to administer exam & care as needed, as indicated from examination findings. I authorize **HealthRock Chiropractic & Sports Medicine** to release information to my doctor and/or insurance company upon my request. A photocopy of this document shall be considered as effective and valid as the original.*
- *I understand that if I am in the litigation for any accident me settlement may be jeopardized by the fact that an intern is rendering my care in the clinic. (student interns can treat me only if **HealthRock Chiropractic & Sports Medicine** inform me prior with my consent)*
- *A parent or an approved individual MUST accompany their minor child on every visit to the clinic.*
- *I acknowledge that I have read **HealthRock Chiropractic & Sports Medicine Notice of Privacy** Practices and acknowledge that I may have a personal copy of the entire Notice upon request.*
- *I consent to the use and/or disclosure of my protected health information as specified in **HealthRock Chiropractic & Sports Medicine Notice of Privacy Practices.***
- *I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment**.***
- *I understand that intentionally providing false insurance information may be considered as fraud. I am fully aware that having health insurance does not release me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company. I hereby authorize HealthRock Chiropractic & Sports Medicine to submit claims, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided, in good faith. I fully agree and understand that the submission of a claim does not release me of my responsibility to ensure that the claim is paid in full.*

I have read and understand the above.

_____	_____	_____
Patient signature	**Relationship to Patient**	**Date**

(Custodial parent or legal guardian if patient is a minor)

Our body is a machine for living. It is organized for that, it is its nature. Let life go on in it unhindered and let it defend itself. - Leo Tolstoy

NOTICE OF PRIVACY PRACTICE

This office is required to notify you 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. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist.

PERMITTED DISCLOSURES:

- Treatment purposes- discussion with other health care providers involved in your care
- Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
- For payment purposes- to obtain payment from your insurance company or any available collateral source.
- For workers compensation purposes- to process a claim or aid in investigation
- Emergency- in the event of a medical emergency we may notify a family member
- Public health and safety in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
- Government agency or Law enforcement –to identify or locate a suspect fugitive or material witness or missing person.
- For military national security prisoner and government benefits purposes.
- Deceased persons –discussion with coroners and medical examiners in the event of your death
- Telephone calls or emails and Appointment reminders -we may call your home to remind you of a missed appointment or leave messages when necessary concerning events or clinic hours.
- Change of ownership- in the event of new ownership

YOUR RIGHTS:

- To receive an accounting of disclosures
- To receive a paper copy of this notice
- To request mailings to an address different than residence
- To request Restrictions on certain uses and disclosures and with whom we release information to
- To inspect your records and receive one copy of your records at no charge, with notice in advance
- To request amendments to information, however like restrictions we are not required to agree to them.

COMPLAINTS:

If you wish to make a formal complaints about how we handle your health information please call Dr. Jinjiang Li at (470)839-8686. If Dr. Li is unavailable, you may make an appointment with our receptionist to see him within 2 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

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

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REGARDING NOTICE OF YOUR RIGHT TO PRIVACY continued….

Note: This office reserves the right to amend this notice of privacy practice at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of ***HealthRock Chiropractic & Sports Medicine*** Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient signature Date

_____

Patient Name (Print)