CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: _____ DOB: _____ SSN#: _____
First, Middle, Last

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ E-mail Address: _____

Sex: ☐M ☐F Employer Name & Address: _____

Type of Work: _____ Who May We Thank for Referring You? _____

Please Check One: ☐ Student ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____ Birthdate: _____ Spouse's SS#: _____

Child's Names: _____ Age: _____ Birthdate: _____

Child's Names: _____ Age: _____ Birthdate: _____

Child's Names: _____ Age: _____ Birthdate: _____

Who is Responsible for Your Bill, You and: ☐ Health Insurance ☐Medicare ☐Self ☐Auto Ins. ☐Work/Comp

Our Advertisements You Have Seen: ☐Yellow Pages ☐TV ☐Radio ☐Health Talk ☐Screening ☐News Paper ☐Mail out

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RESPONSIBLE PARTY INFORMATION (This section MUST be completed if patient is a minor)

Name: _____ DOB: _____ SSN#: _____
First, Middle, Last

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

Insured: _____ Relationship to Patient: _____ SS#: _____ DOB: _____

Insured's Employer: _____ Ins. Phone: ( )_____

Insurance Co: _____ Policy #: _____

Street Address: _____ City: _____ State: _____Zip: _____

SECONDARY INSURANCE INFORMATION

Insured: _____ Relationship to Patient: _____ SS#: _____ DOB: _____

Insured's Employer: _____ Ins. Phone: ( )_____

Insurance Co: _____ Policy #: _____

Street Address: _____ City: _____ State: _____Zip: _____

In Case of an Emergency, please give the name of a relative or friend not living with you.

Name: _____ Relationship to Patient: _____ Home Phone: ( )_____

Address: _____ Work Phone: ( ) _____

City: _____ State: _____ Zip: _____

CURRENT HEALTH CONDITION

Please List Your Chief Health Complaints, Symptoms, or Concerns in the Order of their Severity Below:

1. _____ How Long: _____
2. _____ How Long: _____
3. _____ How Long: _____

What is the Main Reason for Your Appointment Today: _____

- Is Your Condition Due To a(an): A) Auto Accident B) Work Injury C) Gradual Onset D) Unknown E) Other Accident
- Date of Accident/Injury____/____/____ Please Describe: _____
- Were You Disabled From Work? ☐Yes ☐No If Yes, Please List Dates: ____/____/____ to ____/____/____
- Date Symptoms Appeared: _____ Are Your Symptoms: A) Improving B) Getting Worse C) About the same

Circle the Activities That Aggravate Your Condition: A) Standing B) Walking C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing

Have You Had These Symptoms Before? ☐Yes ☐No If yes, when? _____

Have You Seen Another Dr. for This Condition? A) MD B) Chiropractor C) Osteopath D) Acupuncturist E) Dentist F) Therapist

- Dr.'sName:_____DateConsulted____/____/_____Diagnosis_____

Medications You Presently Take: ☐Pain Killers ☐ Muscle Relaxers ☐Anti-Inflammatory ☐Blood Pressure Pills ☐Insulin ☐Anti-Depressants ☐Sleeping Pills ☐Aspirin/Similar ☐Digestive Aids ☐Diet Pills Others: _____

Does Anyone Else in Your Family Have the Same or Similar Condition: ☐Yes ☐No Who: _____

Have You Been Treated For Any Health Condition in the Last Year? ☐Yes ☐No If Yes, Please Explain: _____

_____

Major Accidents, Injuries, or Falls You Have Had in Your Lifetime: _____

DAILY LIFESTYLE & HABITS: Please Fill Chart Below Out Completely.

Alcohol	Daily	2 / week	2 / month	None
Coffee	>5 cups	2-4 cups	1 cup	None
Tobacco	>2 packs	1 pack	<1/2 pk	None
Drugs	Daily	1 / week	1 / month	None
Exercise	Daily	3 / week	1 / week	None
Sleep	>10 hrs.	7-10 hrs.	4-7 hrs.	<4 hrs.
Appetite	Heavy	Moderate	Light	None

FEMALES ONLY:
When was the First Day of your last Cycle?
_____

ARE YOU PREGNANT?
☐Yes ☐No ☐Maybe
PLEASE INITIAL BELOW:
_____

Do you wear: ☐Heal lifts ☐Foot Pads ☐Innersoles ☐Arch Supports

Major Surgery or Operations You Have Had: ☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia ☐ Heart ☐ Low Back ☐ Neck ☐ Knee ☐ Female ☐ Other: _____ Please Give Dates: _____

PAST HEALTH HISTORY

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, as these problems can affect your overall course of Your Care.

PLEASE CHECK ANY OF THE FOLLOWING DISEASES OR CONDITIONS YOU HAVE HAD:

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Anemia	☐ Eczema
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ Auto Immune Disease	☐ Measles
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Heart Disease	☐ Lumbago
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Thyroid	☐ Asthma
☐ Whooping Cough	☐ Cancer	☐ Mental Disorder	☐ HIV Positive	☐ Kidney Stones

***Are you interested in nutritional counseling? YES_____ NO_____

PLEASE CHECK THE BOX OF SYMPTOMS YOU HAVE HAD IN THE PAST 6 MONTHS: ☒

THEN CIRCLE THE SYMPTOMS YOU ARE EXPERIENCING AT THE PRESENT TIME:

☐Headaches

MUSCULO-SKELETAL SYSTEM
- ☐ Head Pain / Problems
- ☐ Neck Pain / Problems
- ☐ Shoulder Pain / Problems
- ☐ Arm Pain / Problems
- ☐ Hand Pain / Problems
- ☐ Mid Back Pain / Problems
- ☐ Chest Pain / Problems
- ☐ Stomach Pain / Problems
- ☐ Low Back Pain / Problems
- ☐ Hip Pain / Problems
- ☐ Leg Pain / Problems
- ☐ Foot Pain / Problems
- ☐ Walking Pain / Problems
- ☐ Chewing / Jaw Pain / Problems
- ☐ General Stiffness

NERVOUS SYSTEM
- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Muscle Cramping
- ☐ Stress

GENERAL SYSTEM
- ☐ Fatigue
- ☐ Allergies
- ☐ Fever
- ☐ Headaches
- ☐ Migraine Headaches
- ☐ Tension Headaches
- ☐ Sinus Headaches
- ☐ Loss of Sleep

GENITO-URINARY SYSTEM
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine
- ☐ Bed-wetting

GASTRO-ENTESTINAL SYSTEM
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas / Bloating After Meals
- ☐ Heartburn / Indigestion
- ☐ Black / Bloody Stool
- ☐ Colitis

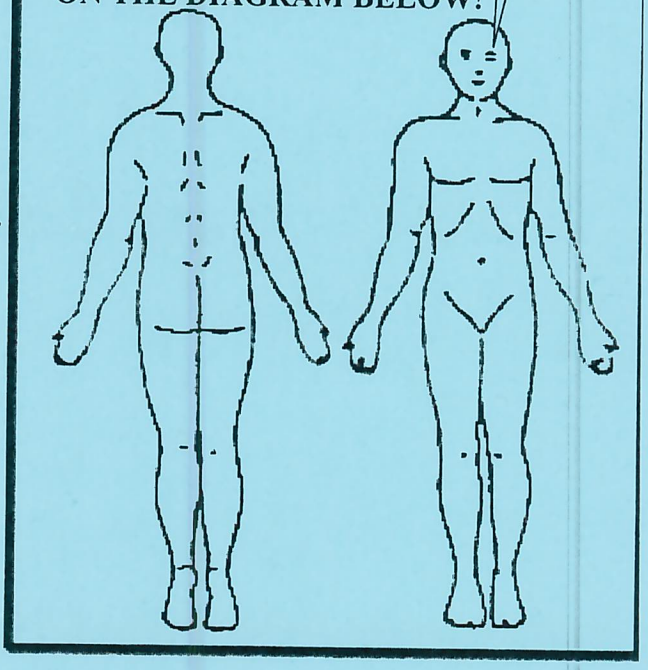
EARS, EYES, NOSE & THROAT
- ☐ Sinus Problems
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Ringing in Ears
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

CARDIO-VASCULAR-RESPIRATORY
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems / Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Please do not forget to draw your pain on me!!!

DARKEN IN THE AREA OF YOUR PAIN OR DISCOMFORT ON THE DIAGRAM BELOW!



PLEASE READ: I understand and agree by signing below that my health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the this Clinic will be credited to my account upon receipt. **However**, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment of these services in full. I also understand that if I suspend or terminate my care in this office, any and all outstanding charges for professional services rendered to me will become immediately due and payable by myself personally at the full retail price. I also agree to pay any collection or legal fees that may occur if I do not pay my bill in a timely fashion and it is placed in collections.

PAST DUE BALANCES WILL INCUR AN INTEREST CHARGE OF 1% EACH BILLING CYCLE.

Patient's Signature: _____ Date: _____

Parent or Guardian's Signature Authorizing Care: _____ Date: _____

OUR PURPOSE AT THIS CLINIC ISTO SUPPORT AS MANY FAMILIES AS POSSIBLE IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND HOW THEIR BODIES FUNCTION AND IN TURN GO OUT AND EDUCATE OTHERS.

SYMPTOM SURVEY FORM

NAME: _____ Pt #: _____ Date: _____

1. **GENERAL SYMPTOMS** (circle as many as apply)

A.	Nervousness	B.	Irritability	C.	Fatigue
D.	Depression	E.	Loss of Sleep	F.	Tension
G.	P.M.S.	H.	Jaw Pain		

2. **HEAD** (circle as many as apply)

A. Headaches: Pain Level: 1. Mild 2. Moderate 3. Severe
How often: (1 2 3 4 5 6) Per (Day / Week / Month)
Are they: 1. Sharp 2. Dull Are they: 1. Constant 2. Intermittent
Where located: 1. Back of Head 2. Forehead 3. Temples
4. Right Side 5. Left Side 6. Behind Eyes

B. Light-Headed	C. Memory Loss	D. Fainting
E. Blurred Vision	F. Double Vision	G. Sensitivity to Light
H. Loss of Balance	I. Hearing Loss	J. Ringing in the Ears

3. **NECK** (circle as many as apply)

A. Neck Pain: 1. Left Side 2. Right Side 3. Both
Pain Level: 1. Mild 2. Moderate 3. Severe
Pain Increased By: 1. Forward Movement 2. Backward Movement
3. Rotate Head Left 4. Rotate Head Right
5. Bend Neck Left 6. Bend Neck Right

B. Stiffness C. Muscle Spasms D. Grinding/Grating Sounds

4. **SHOULDERS** (circle as many as apply)

A. Pain in Joint:	1. Left	2. Right	3. Both
B. Pain across Shoulder:	1. Left	2. Right	3. Both
C. Limitation of Movement:	1. Left	2. Right	3. Both
D. Tension / Muscle Spasms:	1. Left	2. Right	3. Both

5. **ARMS** (circle as many as apply)

A. Pain in Upper Arm	1. Left	2. Right	3. Both
B. Pain in Elbow	1. Left	2. Right	3. Both
C. Pain in Forearm	1. Left	2. Right	3. Both
D. Pins & Needles (Arm)	1. Left	2. Right	3. Both
E. Pins & Needles (Forearm)	1. Left	2. Right	3. Both
F. Numbness in Arm	1. Left	2. Right	3. Both
G. Numbness in Forearm	1. Left	2. Right	3. Both

6. **HANDS** (circle as many as apply)

A. Pain in Wrist	1. Left	2. Right	3. Both
B. Pain in Hand	1. Left	2. Right	3. Both
C. Pins & Needles (Hands)	1. Left	2. Right	3. Both
D. Numbness (Hands)	1. Left	2. Right	3. Both

** SEE BACK FORM TO COMPLETE **

7. **MIDBACK** (circle as many as apply)

A. Midback Pain:	1. Left	2. Right	3. Both
Pain Level:	1. Mild	2. Moderate	3. Severe
Pain Type:	1. Sharp/Stabbing	2. Dull Ache	
B. Muscle Spasm	1. Left	2. Right	3. Both

8. **CHEST** (circle as many as apply)

A. Deep Chest Pain:	1. Left	2. Right	3. Both
Pain Level:	1. Mild	2. Moderate	3. Severe
B. Pain Around Ribs:	1. Left	2. Right	3. Both
C. Shortness of Breath	**D. Irregular Heartbeat**		

9. **ABDOMINAL SYMPTOMS**

A. Abdominal Pain:	1. Mild	2. Moderate	3. Severe
B. Nervous Stomach	**C. Nausea**	**D. Gas**	
E. Constipation	**F. Diarrhea**	**G. Heartburn**	
H. Indigestion	**I. Loss of Appetite**		

10. **LOWBACK** (circle as many as apply)

A. Upper Lumbar Pain	1. Left	2. Right	3. Both
B. Lower Lumbar Pain	1. Left	2. Right	3. Both
C. Sacroiliac Pain	1. Left	2. Right	3. Both
D. Muscle Spasm	1. Left	2. Right	3. Both
** Lowback Pain Level:	1. Mild	2. Moderate	3. Severe

11. **HIP & LEGS** (circle as many as apply)

A. Pain in Buttocks:	1. Left	2. Right	3. Both
Pain Level:	1. Mild	2. Moderate	3. Severe
B. Pain in Hip Joint:	1. Left	2. Right	3. Both
Pain Level:	1. Mild	2. Moderate	3. Severe
C. Pain Down Leg:	1. Left	2. Right	3. Both
Location:	1. Front	2. Back	3. Side
Pain Radiates to:	1. Knee	2. Calf	3. Foot
D. Numbness Down Leg:	1. Left	2. Right	3. Both
Location:	1. Front	2. Back	3. Side
E. Pins & Needles (Leg):	1. Left	2. Right	3. Both
Location:	1. Front	2. Back	3. Side
F. Knee Pains:	1. Left	2. Right	3. Both
G. Leg Cramps:	1. Left	2. Right	3. Both

12. **FEET** (circle as many as apply)

A. Ankle Pain:	1. Left	2. Right	3. Both
B. Swollen Ankle:	1. Left	2. Right	3. Both
C. Foot Pain:	1. Left	2. Right	3. Both
D. Numbness of Feet:	1. Left	2. Right	3. Both
E. Swollen Feet:	1. Left	2. Right	3. Both
F. Cramps:	1. Left	2. Right	3. Both

COMMENTS:

_____

_____

PINHOOK CHIROPRACTIC CLINIC
100 LA RUE FRANCE
LAFAYETTE, LA 70508
Phone (337)237-2273 Fax (337)237-1765

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Pinhook Chiropractic Clinic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Treatment in Open or Common Areas

Note that some of your treatment may be performed in an 'open' area. Private rooms are available upon request by appointment.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Appointment Reminders

Appointment reminders are sent via text and/or email through a system we use, named Demandforce. This method may not be secure as we cannot guarantee the message is received by the intended receiver. You can opt out at any time through Demandforce or requesting from the office. To receive appointment reminders in this manner, we have to have the following authorization:

I hereby consent and state my preference to have Pinhook Chiropractic, Demandforce, and their staff to communicate with me by email or standard SMS/text messaging, in addition to leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave **both** appointment remainders AND my private health information at the following (please fill-in the ones you agree to and note if you want reminders only):

Phone message at the following number _____

Email messages at the following email address _____

Text messages at the following phone number _____

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of PINHOOK CHIROPRACTIC CLINIC.

I understand that the Notice describes the uses and disclosures of my protected health information by PINHOOK CHIROPRACTIC CLINIC and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*

PINHOOK CHIROPRACTIC CLINIC
100 LA RUE FRANCE
LAFAYETTE, LA 70508
Phone (337)237-2273 Fax (337)237-1765

CHIROPRACTIC ASSOCIATION OF LOUISIANA AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your PHI to the Chiropractic Association of Louisiana (CAL). This disclosure will be made if we need the CAL's assistance to receive reimbursement for your services or, we need the CAL's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form, you are giving us authorization to send the CAL this information. You are also giving the CAL authorization to re-disclose your information to the party responsible for the payment of your services, the CAL's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may inspect or copy the information that we may send to the CAL at any time (§164.524).

MARKETING AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your PHI for the purpose of marketing our services. We are specifically requesting authorization to use your information, including your photo, to display testimonials, "Patient of the Week/Month" boards, kid photo boards, as well as promotions and contest displays within the office and on our website.

By signing, you also give us authorization to send you monthly newsletter(s), "Birthday", "Christmas" and "Thank You" cards, as well as other announcements or flyers.

You may inspect or copy the information that we use to contact you for marketing purposes at any time (§164.524).

At no time will this office sell your PHI without a separate written authorization signed by the patient or the patient's legal representative.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosures by anyone who receives the information or has access to this information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

This notice is effective as of _____. This authorization will expire six years after the date on which you last received services from us.

I authorize you to disclose my PHI in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient's Signature or that of Legal Representative Printed Name of Patient or that of Legal Representative

_____ _____
Today's Date If Legal Representative, Indicate Relationship

Informed Consent for Chiropractic Treatment & Acknowledgment of Receipt of Information

To the patient: Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include but are not limited to:

- Increased symptoms and pain
- No improvement of symptoms or pain
- Burns or frostbite (physical therapy)
- Worsening/aggravation of spinal conditions

1) **Stroke:** Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise for the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive date to quantify probability.

2) **Disc Herniations:** Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors: Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.

3) **Soft Tissue Injury:** Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long-term affects for the patient.

4) **Rib Fractures / Dislocation:** The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from things as osteoporosis on their x-rays.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all of these matters. I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

Informed Consent

I hereby authorize and direct Dr. Brad Grizzaffi, together with associates and assistants of his choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustments, various modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

_____ _____

Patient's Name Date

_____ _____

Signature of patient or parent/guardian Witness

Pinhook Chiropractic Clinic
100 La. Rue France, Lafayette, LA. 70508
(337) 237-2273

PINHOOK CHIROPRACTIC CLINIC
100 LA RUE FRANCE
LAFAYETTE, LA 70508
Phone (337)237-2273 Fax (337)237-1765

Authorization to release Protected Health Information to Other Parties
If you would like us to discuss your medical treatment, financial information or other Protected Health Information to another party, please specify name:

SPOUSE/SIGNIFICANT OTHER _____

CHILD_____

PARENT_____

SIBLING_____

OTHER (specify name and relation)_____

By my signature below I give my permission to use and disclose by Protected Health Information in the manner described above.

_____ _____
Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____
Today's Date *Witness Signature*