| Today's Date: |
|---|

# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

| | | |
|---|---|---|
| **Name** *(Last, First, M.I.):* | ☐ M ☐ F | **DOB:** |
| **Address:** | | |
| **Email address:** | | |
| **Home Phone:** | **Cell Phone:** | |
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | | |
| **Spouse/Partner Name:** | **Phone:** | |
| **Patient Employer:** | **Phone:** | |
| **Emergency contact:** | **Phone:** | |
| **Relationship:** | | |

| **Race (circle one):** | **Ethnicity (circle one):** |
|---|---|
| American Indian/Alaska Native | Hispanic or Latino |
| Asian | Not Hispanic or Latino |
| Black or African American | Decline to provide this information |
| Caucasian | |
| Decline to provide this information | **Preferred Language:**_____ |

## PERSONAL HEALTH HISTORY

| **Height:** | **Weight:** | **Current Complaint/Diagnosis:** |
|---|---|---|

**Please circle all Medical conditions for which you are currently under the care of a Medical Doctor:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Arthritis | Chest Pain | Foot Pain | High Blood Pressure | Low Back Pain | Neurological Disorder | Spinal Cord Injury | Ulcer/s |
| Asthma | Diabetes | Genetic Spinal Disorders | Hip Pain | Menstrual Problems | Parkinson's Disease | Stomach Problems | Wrist Pain |
| Anxiety | Dizziness | Hearing Problems | Jaw Pain | Mid Back Pain | Polio | Stroke | |
| Cancer | Epilepsy | Headaches | Joint Disorder | Multiple Sclerosis | Prostate Problems | **Other**: | |
| Cardiac Issues | Eye/vision Problems | Hepatitis | Knee Pain | Neck Pain | Shoulder Pain | | |

**Surgeries within the last 5 years**

| Year | Type |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**TURN OVER**

| **Medication Allergies** | |
|---|---|
| Name the Drug | Reaction You Had |
| | |
| | |
| | |

## HEALTH HABITS AND PERSONAL SAFETY

| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. | | | | |
|---|---|---|---|---|
| **Alcohol** | Do you drink alcohol? | | ☐ Yes | ☐ No |
| **Tobacco** | Tobacco Use: Are you a current or former smoker? | | ☐ Yes | ☐ No |
| | If yes | ☐ year you quit | ☐ # of years smoking | |
| | Do you use smokeless tobacco? | ☐ Yes ☐ No | | |

## FAMILY HEALTH HISTORY

| | AGE | **SIGNIFICANT HEALTH PROBLEMS** |
|---|---|---|
| **Father** | | |
| **Mother** | | |
| **Sibling** | ☐ M ☐ F | |
| | ☐ M ☐ F | |
| | ☐ M ☐ F | |
| | ☐ M ☐ F | |
| | ☐ M ☐ F | |
| | ☐ M ☐ F | |

# Hoosier Family Chiropractic, Inc. Dr. Mary Ann Bough

**Medicare Patients ONLY:** I attest that all the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my provider to release any and all medical records to the Social Security Administration, the Medicare program, its intermediaries or carriers, or to Professional Standards Review Organizations in order to process claims for medical benefits. I authorize payment of benefits to be made directly to my provider, Dr. Mary Ann Bough, on my behalf.

**Signature** _____ **Date:**_____

**Release of Medical Information and Authorization to Pay Insurance Benefits**: I authorize my provider to release any and all information required from my medical records to my insurance carrier(s), or government agencies for the processing of claims for my medical benefits; or to other health care providers as appropriate for continuation of care. I request that my insurance company(s) honor my designation of applicable insurance benefits to my provider for their services and pay all assigned insurance benefits to my provider on my behalf.

**Signature** _____ **Date:**_____

**Financial Payment Agreement**: I recognize that I, the patient and/or the responsible guarantor, am completely responsible for all accounts in my name. My provider's office will assist me in obtaining insurance benefits when there are benefits available and they are assigned to my provider. I understand that insurance is not a guarantee of payment, but a quote of benefits. It is the responsibility of me, the patient, to ensure that insurance payments are processed and paid punctually to my provider. In the case of default payment, I promise to pay any legal interest on the balance due together with any collection cost and reasonable attorney fees incurred to collect any outstanding balances on my account.

Wellness plans are available to patients for routine maintenance (non-restorative) care. If you are eligible and interested please inquire at the front desk. You may also obtain a copy of our Fee Schedule and full Financial Policy upon request.

**Signature** _____ **Date:**_____

**HIPAA**: I acknowledge that a copy of this office's HIPAA Notice of Privacy Practices has been made available to me. This notice describes how medical information about me may be used and/or disclosed and how I can access this information. The Notice of Privacy Practices is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance and may, also, be found on the web at http://www.hhs.gov.

**Signature** _____ **Date:**_____

# Hoosier Family Chiropractic, Inc. Dr. Mary Ann Bough

## Authorization for Release of Personal Health Information

During the course of your care we may disclose medical information about you to other practitioners treating you, your insurance company, workman's compensation representative, and/or others involved in your care.

We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke or cancel your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you must notify us in writing. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

Please indicate below individuals to whom you authorize us to release medical information:

_____ _____

**Name** **Relationship to Patient**

**Phone Number: _____**

_____ _____

**Name** **Relationship to Patient**

**Phone Number: _____**

_____ _____

**Name** **Relationship to Patient**

**Phone Number: _____**

**Patient Name: _____ Date: _____**

**Patient Signature: _____**

**Hoosier Family Chiropractic, Inc.**
**Informed Consent to Care 2016**

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

***I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.***

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____