File # _____ Dr. Larry Formanek, D.C.

Date _____ **Patient Health History** Knoxville Chiropractic Clinic, P.C.

In order to provide you the best chiropractic care, please complete the form as accurately as possible. All information is CONFIDENTIAL

PATIENT INFORMATION AND DEMOGRAPHICS

First Name _____ M.I. _____ Last _____ Nickname _____

Address _____ City _____ State_____ Zip_____

Telephone (Home) _____ (Cell) _____ (Work) _____

Email Address _____

Age _____ Birth Date _____ ☐ Male ☐ Female

Occupation_____ Employer/ School _____

☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name _____ # of children _____

Emergency Contact _____ Telephone # _____ Relationship _____

How did you hear about us? _____

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's Name _____ Date of last adjustment? _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ White (Caucasian) ☐ Other ☐ I decline to answer

Preferred Language: ☐ English ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I decline to answer

FINANCIAL INFORMATION

☐ I will be paying for the services myself (Cash Patient) ☐ Health Insurance* ☐ Auto Insurance ☐ Worker's Compensation

☐ Other If minor, who is responsible for the bill? _____

*** Please provide your insurance card to the front desk. A copy will be placed in your file**

PURPOSE OF THIS VISIT

What caused your symptoms? _____

Reason for this visit? _____

My symptoms started: ☐ gradually ☐ suddenly

When did your symptoms start? _____

My symptoms are getting: ☐ better ☐ worsening ☐ not changing

Intensity of your symptoms: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Frequency of pain: ☐ Constant (75-100% of the day) ☐ Frequent (50-75% of the day)
☐ Intermittent (25-50% of the day) ☐ Occasional (0-25% of the day)

Please select all that apply regarding your pain:

☐ Achy	☐ Numbness	☐ Shooting	☐ Stiffness
☐ Burning	☐ Radiating	☐ Soreness	☐ Tingling
☐ Dull	☐ Sharp	☐ Stabbing	☐ Other

The symptoms worsen when I….._____

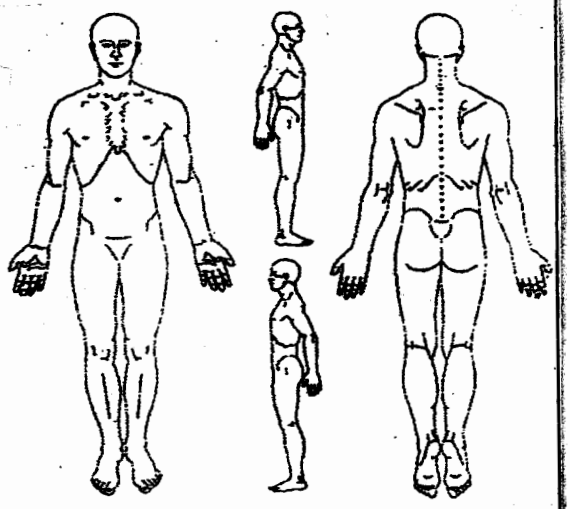
The symptoms improve when I…._____

Home remedies used: ☐ Ice ☐ Heat ☐ Tylenol ☐ Ibuprofen ☐ Other

Who have you seen for your symptoms? ☐ No One ☐ Chiropractor ☐ MD
☐ Surgeon ☐ Physical Therapist ☐ Other

What treatments were performed? ☐ X-ray ☐ MRI ☐ Therapy ☐ Other

Please indicate where you have pain or other symptoms:



Comments _____

For office use only: Height _____ inches Weight _____ lbs. BP _____ Pulse _____ Temp._____

Health and Social History

Have you ever had any surgeries? ☐ Yes ☐ No Please State: _____

Have you ever had any car accidents? ☐ Yes ☐ No Please State: _____

Sports Injuries, falls, broken bones? ☐ Yes ☐ No Please State: _____

Smoking Status: ☐ Every day smoker/ # of packs per day: _____ ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Do you consume alcohol? ☐ Yes ☐ No # of drinks per week: _____

Do you exercise? ☐ No ☐ Infrequently ☐ Occasionally ☐ Frequently ☐ Regularly

Are you pregnant? ☐ Yes ☐ No Number of weeks: _____ Anticipated due date: _____

Are you currently taking any medications? ☐ Yes ☐ No (Please include prescriptions and regularly used over the counter medications.)

_____

_____

_____

Do you have any medication allergies? ☐ Yes ☐ No Please State: _____

Personal History & Review of Systems Please check all that you have or have had:

☐ AIDS	☐ Fever	☐ Nosebleeds	☐ Pacemaker	☐ Hot flashes
☐ Alcoholism	☐ Loss of Sleep	☐ Sinus infection	☐ Poor circulation	☐ Menstrual pain
☐ Allergies	☐ Uncontrolled sweating	**Muscle/Joint/Bone**	☐ Rapid heartbeat	☐ painful intercourse
☐ Anemia	☐ Weight gain	☐ Arthritis	☐ Swelling of ankles	☐ vaginal discharge
☐ Anxiety/Nervousness	☐ Weight loss	☐ Disc degeneration	☐ Varicose Veins	
☐ Appendicitis	**Gastro-intestinal**	☐ Back pain/stiffness	**Skin**	
☐ Asthma	☐ Bloating	☐ Neck pain/stiffness	☐ Changes in moles	
☐ Cancer	☐ Constipation	☐ Muscle pain	☐ Bruises easily	
☐ Chills	☐ Diarrhea	☐ Muscle spasm	☐ Hives	
☐ Cold extremities	☐ Excessive thirst	☐ Osteoporosis	☐ Itching	
☐ Decreased activity	☐ Hemorrhoids	☐ Joint pain	☐ Rashes	
☐ Depression	☐ Indigestion	☐ Swollen joints	☐ Scars	
☐ Diabetes	☐ Nausea	☐ Scoliosis	☐ Sores that won't heal	
☐ Dizziness	☐ Change in appetite	**Urinary**	**Males only**	
☐ Epilepsy	☐ Stomach pain	☐ Blood in urine	☐ Breast lump	
☐ Eye Pain	☐ Vomiting	☐ Frequent urination	☐ Erectile dysfunction	
☐ Fatigue	**Ear/Nose/Throat**	☐ loss of bladder control	☐ Lump in testicle	
☐ Kidney Infection	☐ Blurred vision	☐ nocturia (bedwetting)	☐ Prostrate problems	
☐ Kidney Stones	☐ Double vision	☐ painful urination	☐ Penis discharge	
☐ Loss of memory	☐ Earache	☐ trouble starting/stopping stream	☐ Sore penis	
☐ Migraine Headache	☐ Loss of hearing	**Cardiovascular**	**Females only**	
☐ Sciatica	☐ Ringing in ears	☐ Chest pain	☐ Breast lump	
☐ Shortness of Breath	☐ Hoarseness	☐ High blood pressure	☐ Nipple pain/discharge	
☐ Stroke	☐ Difficulty swallowing	☐ Low blood pressure	☐ Abnormal pap smear	
☐ Thyroid Condition	☑ Persistent Cough	☐ Irregular heartbeat	☐ Irregular cycle	

Family History Please note any family history of the following conditions and include relationship of relative to you:

☐ Cancer _____	☐ Arthritis _____	☐ Spine or back disorder _____
☐ Diabetes _____	☐ Epilepsy _____	☐ Multiple Sclerosis _____
☐ Headache _____	☐ Heart Disease _____	☐ Psychological Problems _____
☐ High Blood Pressure _____	☐ Stroke_____	☐ Other _____

☐ **I choose to decline receipt of my clinical summary after every visit.** (These summaries are often blank because of the nature and frequency of chiropractic care.)

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor. The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

_____ _____

Patient or Guardian of Minor Patient s Signature Date

Knoxville Chiropractic Clinic, P.C. Dr. Larry Formanek
115 E. Main Street
Knoxville, IA 50138
(641)842-3007

Patient
First Name _____ **M.I.** _____ **Last** _____ **Chart #**_____

Financial Agreement: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Knoxville Chiropractic Clinic, P.C. which are not paid by my health insurance or other payer. I clearly understand I am personally responsible for payment and that all charges are due and payable when I receive the bill, unless other arrangements are made in advance. I also understand that I may terminate my care and treatment, however upon doing so any fees for professional services rendered to me will be immediately due and payable.

Assignment for Direct Payment: I authorize the payment of any insurance (including healthcare insurance and/or auto insurance) benefits for health care services or goods be made directly to Knoxville Chiropractic Clinic, P.C., 115 E. Main Street, Knoxville, IA 50138

Authorization for Release of Information: Knoxville Chiropractic Clinic, P.C. may release information from my chiropractic health records to any health care provider involved in my care and treatment. Knoxville Chiropractic Clinic, P.C. may also release information from my chiropractic health records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare or Medicaid programs, and my employer's workers' compensation carrier. I acknowledge that upon disclose of my chiropractic health record information to an insurance company or other payer pursuant to this authorization, Knoxville Chiropractic Clinic, P.C. is no longer responsible for the confidentiality of any information known or possessed by the payer.

Informed Consent for Health Services: I hereby request and consent to the performance of chiropractic treatment including chiropractic adjustments and other chiropractic procedures, including various modes of physical and physiotherapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Larry M. Formanek, D.C. of the Knoxville Chiropractic Clinic, P.C. and whomever he may designate as his assistants to administer treatment.

I have had an opportunity to discuss with the doctor of chiropractic named above or with other office and clinic personnel the nature and purpose of chiropractic adjustments and other procedures, I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon facts that are known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions and any future condition(s) for which I seek treatment with Dr. Larry Formanek, D.C. and Knoxville Chiropractic Clinic, P.C.

Signature of Patient _____ **Date:** _____
or Parent/Guardian of Minor Patient

Consent to Treatment of Minor Child: I hereby authorize Dr. Larry M. Formanek and whomever he may designate as assistants to administer chiropractic care including x-rays described above for the treatment of my minor child or the minor for which I am legally responsible.

Birth date of Child: _____/_____/_____

Signature of Parent/Guardian: _____ **Date:** _____

Witness: _____ **Date:** _____

Knoxville Chiropractic Clinic, P.C. Dr. Larry Formanek
115 E. Main Street
Knoxville, IA 50138
(641)842-3007

Notices of Privacy Practices
Abbreviated

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

How medical information about
you may be used and disclosed
and how you can access this information

We may use or disclose to others your medical information for the purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization. We are required to obtain your authorization for the sale of your protected health information and marketing that results in direct or indirect payment from a third party for the communication.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, notification of a breach of unsecured protected health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The Effective Date at the bottom of this page indicates the date of the most current Notice in effect.

You have a right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice and you would like one, please ask at the front desk and we will provide you with a copy.

If you have questions, concerns or complaints about the Notice or your health information, please contact: *Rebecca L. Darnell* of our office at *(641)842-3007.*

_____/_____

Signature of Patient or Parent/Guardian of Minor Patient **Date**

Form: Effective 09/17/2013