Body Works Chiropractic Studio

Dr. Danielle Hoeckele, D.C.

ADULT HEALTH PROFILE

Today's Date: _____

PATIENT DEMOGRAPHICS SSN:_____

Name:_____ Birth Date:_____ Age:_____ Sex: ☐ M ☐ F

Address:_____ City:_____ State:_____ Zip:_____

Phone: (H)_____ (C)_____ Email:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed How many children? _____

Emergency Contact: _____ Phone number: _____

Relation: _____

Employer:_____ Type of Work:_____

Family Physician:_____ Date of Last Visit:_____

Have You Seen a Chiropractor Before?_____ Date of Last Visit:_____

*Whom may we thank for referring you to our office?*_____

CURRENT HEALTH CONCERN

☐ *Check this box if there are no current concerns and this assessment is to ensure optimum health, function and wellness.* ***INSURANCE MAY DENY CLAIM.***

Please identify the condition(s) that brought you to this office and circle the corresponding number to rate the complaint from 0-10 (0 being no pain, 10 being the worst). Then please fill out questions that follow:

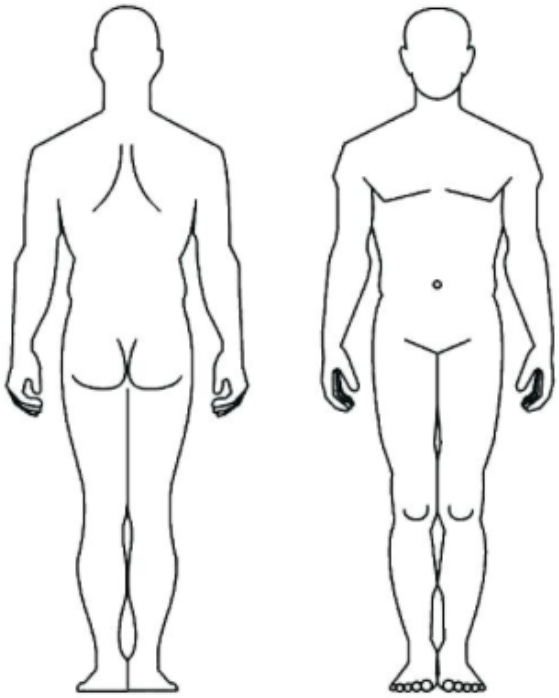
Primary Complaint: _____

Intensity: 1 2 3 4 5 6 7 8 9 10

- When did you first notice it? _____
- Circle the quality: Sharp dull ache burning tingling throbbing spasm other: _____
- Describe what happened: _____
- How often does it occur: _____

- What relieves it: _____
- What makes it worse: _____
- Does it radiate to other parts of your body: _____
- Have you seen any other health care professional for this concern? ☐ Yes ☐ No
    - If Yes:
        - Name: _____
        - Last Visit: _____

All Other Complaints Can Be Listed Below. Please Order them in accordance to the level of discomfort you are experiencing.



1. _____
2. _____
3. _____
4. _____
5. _____

REVIEW OF SYSTEMS

MS (Muscles, Bones, Joints) ❑ No Problems ❑arthritis, ❑back problems, ❑elbow/wrist pain, ❑foot/ankle pain, ❑joint muscle pains/stiffness, ❑knee injury, ❑neck pain, ❑scoliosis, ❑shoulder problems, ❑swelling/redness/deformity of joints, ❑TMJ issues. Other:_____

Neurological/Psychiatric (Brain & Nerves) ❑ No Problems ❑anxiety and/or panic, ❑depression, ❑difficulty concentrating, ❑dizziness, ❑epilepsy or seizures, ❑headache, ❑ memory issues, ❑ numbness, ❑pins and needles, ❑sleeping issues, ❑stroke, ❑weak muscles.
Other:_____

Head and ENT ❑ No Problems ❑blurred or double vision, ❑chronic ear infections, ❑dental problems, ❑difficulty swallowing, ❑ear or hearing problems, ❑earache, ❑vision problems, ❑headaches or migraines, ❑nose congestion or sinus trouble, ❑postnasal drip, ❑recent hearing loss, ❑ringing in ears, ❑sore throat, ❑TMJ problems. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems ❑blood clots, ❑chest pain or tightness, ❑dizziness, ❑excessive bruising, ❑high blood pressure, ❑high cholesterol, ❑leg pain upon walking, ❑low blood pressure, ❑lower extremity edema, ❑swollen legs or feet. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems ❑asthma, ❑emphysema, ❑persistent cough, ❑pneumonia, ❑ tuberculosis, ❑shortness of breath, ❑snoring issues, ❑wheezing.
Other: _____

GI (Stomach & Intestines) ❑ No Problems ❑abdominal pain, ❑black or blood in stools, ❑bloating, ❑change in bowel habits, ❑constipation, ❑heartburn, ❑nausea, ❑vomiting.
Other:_____

GU (Kidney & Bladder) ❑ No Problems ❑painful or frequent urination, ❑urgency, ❑incontinence.
Other: _____

Endocrinologic (Glands) ❑ No Problems ❑feeling hot or cold all the time, ❑diabetes, ❑excessive thirst, ❑hyperthyroidism, ❑hypothyroidism, ❑thyroid problems. Other: _____

Dermatologic/Hematologic (Blood/Lymph) ❑ No Problems ❑easy bruising, ❑eczema, ❑excessive hair loss, ❑change in hair or nails. Other:_____

Allergic/Immunologic ❑ No Problems ❑Seasonal allergies, ❑hay fever symptoms, ❑itching, ❑frequent infections. Other: _____

PAST HEALTH HISTORY

Major Surgery/Operations (Please Check or Describe):

☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia ☐ Heart ☐ Back

☐ Neck ☐ Leg ☐ Fusions Other: _____

Have you ever been diagnosed with any of the following conditions?
Mark with P = Past or C=Currently

___Broken Bone	___Dislocation	___Tumor	___Cancer
___Rheumatoid Arthritis	___Osteoarthritis	___Scoliosis	___Heart Attack
___Diabetes	___Seizures	___Disability	___Spinal Surgery

Other Serious Medical Condition: _____

Physical Stresses

Any significant injuries, falls, or traumas during infancy or childhood? ☐Yes ☐No ☐Unsure
(if yes, please explain): _____

Any significant injuries, falls, or traumas during adulthood? ☐Yes ☐No ☐Unsure
(if yes, please explain): _____

Any hospital visits? ☐Yes ☐No
(if yes, please explain): _____

Any daily repetitive postures or movements (sitting, factory work, driving, etc)? ☐Yes ☐No
(if yes, please explain): _____

Any hobbies that are physically strenuous or have repetitive movements? ☐Yes ☐No

(if yes, please explain): _____

Any vehicle accidents? ☐Yes ☐No
(if yes, please explain):_____

Hobbies/Recreational Activities/Exercise Regime?_____

Chemical Stresses:

Do you take prescription or over-the-counter medications? ☐Yes ☐No

If yes, please provide a list or give name and reason: _____

_____

Do you take any supplements? ☐Yes ☐No

If yes, please provide a list or give name and reason: _____

_____

Do you smoke? ☐Current ☐ Past ☐ Never If current, how many packs per day? _____

Do you drink alcohol? ☐Yes ☐No How many drinks per day? _____

Exposed to pollutants, strong smells, or chemicals regularly? ☐Yes ☐No ☐Occasionally

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Mental/Emotional Stress:

Rank the following areas of your life from 0 to 10 (0=no stress, 10=maximal stress):

Relationships: Work: Finances: Hobbies:

Time Management: Quality of Sleep: Health:

Do you practice any relaxation regimen to reduce your stress?
Yes No Occasionally

Reason you are here:

What daily activities are being restricted by your current health problems? _____

_____

People seek chiropractic care for many different reasons and have certain expectations. Please indicate your reason for seeking out chiropractic care:

☐ Relief ☐ Corrective ☐ Prevention ☐ Wellness

Accuracy of Information

I acknowledge that the above information is true and up-to-date to the best of my knowledge. If new information becomes available, I agree to present it to Body Works Chiropractic Studio in order to keep my health information accurate.
By signing below, I agree to receive chiropractic care.
Name: _____ Date: _____

Sign: _____

Body Works Chiropractic Studio

Informed Consent to Care

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 occur 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 to one 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 at Body Works Chiropractic Studio for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

DATED THIS ____ DAY OF _____, 20___

_____ _____

Patient's Signature Doctor's Signature

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____
DOB: _____
Printed name of person legally authorized to sign for
Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

Remarks:

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

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

Patient Signature: _____

Date:_____

Body Works Chiropractic Studio

I grant Body Works Chiropractic Studio and its employees the right to take photographs of me with connection to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Body Works Chiropractic Studio may use such photographs of me and for any lawful purpose, including such purposes as publicity, illustration, advertising, and web content.

I am at least 18 years of age and have read and understand the above:

Signature_____
Printed Name_____

If under 18 years of age the legal guardian or parent has read and understands the above:

Signature_____

Printed Name_____

Body Works Chiropractic Studio

NOTICE OF PRIVACY PRACTICES FOR PROTECTED 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.

Our Legal Duty

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

Uses and Disclosures

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**:

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent

activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health- related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY
TIME.

In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health- record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Patient Rights

Right to Request Restrictions. You may request that we restrict the uses and disclosures of your health record information for treatment, payment
and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Receive Confidential Communications. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy. You have the right to inspect, copy and request amendments to your health records including electronic health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying,

postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request. We are obligated to notify you if there is a breach of your PHI unless there is a low probability of PHI compromise.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to: Privacy Officer, Premier Wellness Chiropractic, 411 Congress Parkway, Suite C, Crystal Lake IL 60014

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

_____	_____	_____
Patient Name	**Patient Signature**	Date
_____	_____	_____
Name of Personal Representative	Signature of Personal Representative	Date

Legal Authority of Personal Representative: _____