HOUMA-THIBODAUX
SPINE & REHABILITATION

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## PATIENT INFORMATION

**Date**_____ **Name**_____ **Male/Female** **DOB**_____
**Address**_____ City,St & Zip_____
**Home ph.**_____ **Wk ph**._____ **Cell ph**._____
**Email**: _____ **Do you want to receive reminders through text & email?** ❑ Yes ❑ No
**Would you like to receive newsletters, promotional offers through email?** ❑ Yes ❑ No
**Status:** Single/Divorced/Widowed/Married **Spouse's name**_____
**SS#**_____ **How did you hear about our clinic?** Newspaper Yellow Pgs. Sign Website
**Referral-by whom**_____
**Work Status**: ❑ Employed ❑ Full-Time student ❑ Part-Time Student ❑ Retired ❑ Other
**Employer/School**_____
**Emergency contact**_____ **Relationship**_____ **Ph**._____
**Other**_____

## PATIENT FINANCIAL RESPONSIBILITY

Finacial responsibility? Self _____ Other:_____ Method of payment: Cash Check Credit Card
Insurance:_____Policy/ID #_____ Group #_____
Insured_____ Insured DOB_____ Insured SS#_____Relationship to Insured_____
**Do you have a secondary insurance? ❑ Yes ❑ No (If yes, please fill out information below)**
Insurance:_____Policy/ID #_____ Group #_____ Insured_____ Insured DOB_____ Insured SS#_____ Relationship to insured_____

I, the undersigned, certify that I (or my dependent) have insurance with the above carrier and assign directly to Houma-Thibodaux Spine & Rehabilitation all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature_____

## PATIENT CONSENT

I understand that some of my health information may be used and/or disclosed by the office to carry out treatment, payment, or health care operations, and that for more complete descriptions of such uses and disclosures, I should refer to the office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form. I understand that I may request restrictions on how my information is disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this consent; but only to the extent that the office has not taken action in reliance thereon and also proved that I do so in writing. I understand that for my protection, any request to amend my health information or to access my medical records must be made in writing.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or 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, strokes, 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 the facts then 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 an 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 condition and for any future condition(s) for which I seek treatment.

**Please sign after reading/agreeing to the conditions of the Patient Financial Responsibility, Authorization & Consent.**
**Patient also acknowledges they received a copy of the Form 8 Notice of Patient Privacy Policy.**

Signature_____ Date_____

# PARTIAL ASSIGNMENT OF THE CAUSE OF ACTION,

# ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

(Agreement)

I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities (Apayers@), which may elect, or be obligated, to pay proceeds to me for any reason, to pay directly to, and exclusively in the name of **Houma-Thibodaux Spine & Rehabilitation, 430 Corporate Dr., Houma, LA. 70360** in the amount of the full charges incurred by me at the Office, past or future, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("my charges"). I further grant a contractual lien to **Houma-Thibodaux Spine & Rehabilitation** with respect to my charges, however, I understand that nothing in this Agreement shall be construed as an election by **Houma-Thibodaux Spine & Rehabilitation** to claim protection under any statutory lien law. For the purposes of this Agreement, proceeds shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as proceeds relating to the following insurance coverage's: individual/group health, disability, worker's compensation, medical payments benefits, personal injury protection, lost wages, lost services, no-fault benefits, uninsured and underinsured motorist coverage, liability coverage, property damage coverage, and malpractice coverage's.

I further agree that, in the event a payer refuses to pay Houma-Thibodaux Injury & Rehabilitation, I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to Houma-Thibodaux Injury and Rehabilatation, as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office=s name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to **Houma-Thibodaux Spine & Rehabilitation** regarding my charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of the Office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon its request.

I hereby authorize and direct **Houma-Thibodaux Spine & Rehabilitation** to file my claims with my health and/or automobile insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g., liability, med pay, attorneys, etc.), I hereby authorize and direct **Houma-Thibodaux Spine & Rehabilitation** to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment.

I hereby direct all payers to release to **Houma-Thibodaux Spine & Rehabilatation** any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize **Houma-Thibodaux Spine & Rehabilitation** to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize **Houma-Thibodaux Spine & Rehabilitation** to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due **Houma-Thibodaux Spine & Rehabilitation** for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Houma-Thibodaux Spine & Rehabilitation** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **Houma-Thibodaux Spine & Rehabilitation** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **Houma-Thibodaux Spine & Rehabilitation** and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

I agree that is payment is not made in a timely manner and should this office find it necessary to place my account with an agency for collection, I agree to pay a collection fee of 50% of the amount owed at the time of placement. In addition, I also agree to pay any and all court costs and attorney fees at the rate of 33.3% of $75.00, whichever is greater, on any balance due and owing. By signing the front of this document you have agreed to the above.

Rev. 03-29-06

HOUMA-THIBODAUX
SPINE & REHABILITATION
430 Corporate Drive Houma, La 70360
(985) 873-8586

# *Notice of Patient Privacy Policy*

**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.**

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

**Our Privacy Officer is Dawn Kern**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www."Click & Type" , calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

## Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

**Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent**

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

**Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization**
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

*disclosures of psychotherapy notes*
*uses and disclosures of Protected Health Information for marketing purposes;*
*disclosures that constitute a sale of Protected Health Information;*
*Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object**
In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**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 or general condition. 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 health care.

**Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**
We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

**Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

## Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office*. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information

as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

**You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

***You have the right to be notified by our office of any breech of privacy of your Protected Health Information.***

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

## Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:* *http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf*

*Or our office can provide you with a written form in which to file your complaint.* You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Dawn Kern you may contact our Privacy Officer, or any staff member, including Dr. Beau Porche or Dr. Jake Bordelon at the following phone number (985) 873-8586 or our website, at www.houmathibodauxspineandrehab.com for further information about the complaint process.

This notice was published and becomes effective on March 29, 2023

HOUMA-THIBODAUX SPINE & REHABILITATION

# Consent to use PHI

**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**
Your Protected Health Information will be used by Houma Thibodaux Spine & Rehab 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.
Houma Thibodaux Spine & Rehab may request previous and/or ongoing health records from other providers for the purpose of patient history and/or treatment purposes. _____Patient Initials

**Notice of Privacy Practices**
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

**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 PHI.
- 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.

**Notice of Treatment in Open or Common Areas**

You will be notified of treatment in an open or common area prior to treatment, private areas available upon request.

**Revocation of Consent**
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Information to Be Used or Disclosed** The information covered by this authorization includes: _____

_____

**Persons Authorized to Use or Disclose Information** Information listed above will be used or disclosed by:
Name of Person Organization:

_____

**Expiration Date of Authorization**
This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

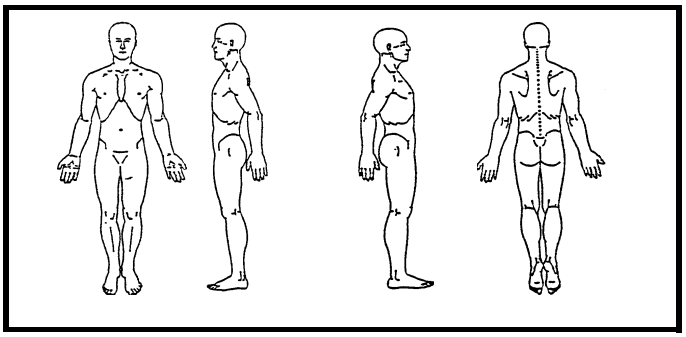
***By my signature below I give my permission to use, disclose and request my health information.***

| | |
|---|---|
| Patient or Legally Authorized Individual Signature | Date |
| Print Patient's Full Name | Time |
| Witness Signature | Date |

# Houma-Thibodaux Spine & Rehabilitation **Patient Health Questionnaire**

**Patient Name:** **Date:**

1. When did your symptoms start:_____
2.Describe your symptoms and how they began:_____
_____
3. Mark a (x) on the picture where you have pain or other symptoms:



4. How often do you experience your symptoms?
____Constantly (76-100% of the day)
____Frequently (51-75% of the day)
____Occasionally (26-50% of the day)
____Intermittently (0-25% of the day)

5.What describes the nature of your symptoms?
____Sharp ____Shooting
____Dull Ache ____Burning
____Numb ____Tingling

6.How are your symptoms changing?
____Getting Better
____Not Changing
____Getting Worse

7.How bad are your symptoms:
…at their worse (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)
…at their best (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

8. What activities make your symptoms worse?_____
…symptoms better?_____

9. Who have you seen for your symptoms?
____No One ____Physical Therapist
____Other Chiropractor Other:_____
____Medical Doctor _____

10.Have you had any of the following:
X-rays (date)_____
MRI (date)_____
CT Scan (date)_____
Other (date)_____

11.What do you hope to get from this visit/treatment? **(Select all that apply)**
____Reduce symptoms ____Explanation of condition/treatment ____How to prevent this from occurring
____Resume/increase activity ____Learn how to take care of this on my own Other:_____

## Patient History

(Please check all symptoms you have ever had, even if they do not seem related to your current problem.)

____Headaches
____Neck Pain
____Upper Back Pain
____Mid Back Pain
____Low Back Pain
____Shoulder Pain
____Elbow/Upper Arm Pain
____Wrist/Hand Pain
____Hip/Upper Leg Pain
____Knee/Lower Leg Pain
____Ankle/ Foot Pain
____Jaw Pain
____Joint Swelling/Stiffness
____Arthritis/Rheumatoid Arthritis
____General Fatigue

____Muscular In coordination
____Visual Disturbances
____Dizziness
____High Blood Pressure
____Chest Pains
____Heart Attack
____Stroke
____Angina
____Kidney Stones/Disorder
____Bladder Infection
____Painful Urination
____Loss of Bladder Control
____Prostate Problems
____Abnormal Weight Loss/Gain
____Loss of Appetite

____HIV/Aids
____Hepatitis
____Liver/Gall Bladder Disorder
____Cancer
____Tumor
____Asthma
____Chronic Sinusitis
____Diabetes
____Smoking/Use of Tobacco
____Drug/Alcohol Dependence
____Allergies
____Depression
____Systemic Lupus
____Epilepsy
____Dermatitis/Eczema/Rash

**FEMALES ONLY**
____Birth Control Pills
____Pregnancy
____Hormonal
____Replacement

**FAMILY HISTORY**
____Rh. Arthritis
____Heart Problems
____Diabetes
____Cancer
Other:_____

Medication Allergies?
_____
_____

List any medications &/or vitiamins you are taking:_____
_____
List any surgical procedures:_____
Other Health Issues:_____

**Patient's Signature:**