Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date:_____

Name: _____ Date of Birth:_____ (Age: _____)

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

Home Phone: _____ Cell: _____ □ Male □ Female

Email: _____ Marital Status: □ Married □Single □Divorced □Seperated □Widowed

Your Occupation: _____ Your Employer: _____

Spouse's Name: _____ Spouse's Occupation: _____

Children (under 18) Name's (Age): 1. _____ ( ) 2. _____ ( ) 3. _____ ( ) 4. _____ ( )

Referred by: □Friend/Family- Name: _____ □Other___ _____

Payment for Services will be by: □Self-Pay □Health Insurance: (Ins. Carrier: _____)
□Medicare □ Medicaid □Automobile Insurance □Worker's Comp.

IMPORTANT TO READ: Your body was created with everything it needs to be healthy and heal itself. If your body is not healthy or healing itself, we want to know why that is, correct the cause of the problem and allow your body to function normally, with optimal health. The information you fill out below is important to help us understand what might be causing your body not to be healthy as it should.

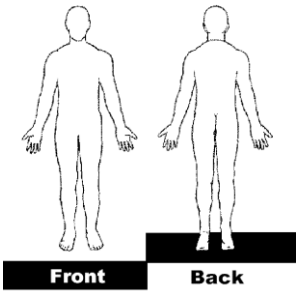
CURRENT HEALTH CONDITION

Describe Present Symptoms/Complaints: Rate the severity of your symptom 1-10 (1-mild, 10-severe)

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

Mark the areas where you are experiencing symptoms.
Next to each area you mark the severity of the symptom on a scale of 1-10 (1-mild, 10-severe)

X = pain
// = pins/needles
+ = numbness



Symptoms: □ Come and go □ Constant Symptoms are worse: □ Morning □Afternoon □ Night

Symptoms started: □ Suddenly □ Gradually When did the problem start: _____

Describe how the problem started: _____

Have you ever had this before: □No □Yes When: _____

Is this condition interfering with work: _____ Sleep: _____ Routine: _____ Other: _____

Is this condition getting progressively worse? _____

Pains are: □ Sharp □ Dull □Radiating □ Localized

Other Doctors seen for this condition (include treatment date): _____

(over please) ⟶

Please check the following activities that aggravate your condition:

☐ Bending ☐ Reaching ☐ Turning head ☐ Coughing ☐ Sitting ☐ Straining at stool
☐ Lifting ☐ Sneezing ☐ Walking ☐ Lying down ☐ Standing ☐ Other: _____

Please check the following activities that relieve your condition:

☐ Bending ☐ Sitting ☐ Lifting ☐ Standing ☐ Lying down ☐ Turning head
☐ Reaching ☐ Walking ☐ Other: _____

Please check any additional symptoms you may be experiencing:

☐ blurred vision ☐ buzzing in ears ☐ cold feet ☐ cold hands ☐ cold sweats ☐ concentration loss
☐ constipation ☐ depression ☐ diarrhea ☐ dizziness ☐ face flushed ☐ fainting
☐ light bothers eyes ☐ heavy head ☐ fever ☐ headaches ☐ insomnia ☐ fatigue
☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ stiff neck ☐ ringing in ears ☐ stomach
☐ low resistance to colds ☐ numbness in fingers ☐ numbness in toes
☐ pins & needles in arms ☐ pins & needles in legs ☐ shortness of breath

Accident History: ☐ Auto ☐ Job ☐ Other 1. _____ Date:_____

☐ Auto ☐ Job ☐ Other 2. _____ Date:_____

☐ Auto ☐ Job ☐ Other 3._____ Date:_____

Health History:

List any hard falls you have taken (even as a child):

1. _____
2. _____
3. _____

Have you been to a chiropractor before? _____ For what periods of time: _____

What medications are you taking? (How Long?)_____

Have you had surgery? _____ What? _____ When?_____

What side effects have you experienced from the drugs and surgery? _____

Have you had a history of: ☐ Stroke (date: _____) ☐ Diabetes ☐ Significant issues with depression or anxiety

☐ Cancer (type: _____ Date: _____ Is it in remission: Yes No)

Do you smoke or use tobacco products? _____

IMPORTANT TO READ: Today, after we discuss your health history, we will perform a spinal examination and chiropractic x-ray to help us find the cause of your health problem. After your visit, we will have you schedule your Chiropractic Report of Findings, where we will discuss with you what can be done to correct the cause of the problem and help you attain and maintain optimal health. If you have any questions, please feel free to ask at any time.

As a result of my chiropractic care, I would like to (please check all that apply):

☐ Feel better quickly ☐ Have a healthlier body by keeping my nerve system healthy
☐ Have a healthier spine ☐ Live a healthier lifestyle

Patient's Signature:_____ Date:_____

Philippians 4:6

Don't worry about anything; instead, pray about everything. Tell God what you need, and thank him for all he has done.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal spiritual, physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

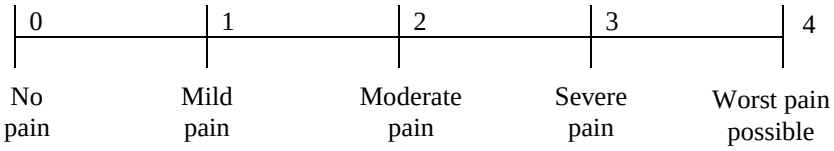
_____ _____
(signature) (date)

Functional Rating Index (FRI)

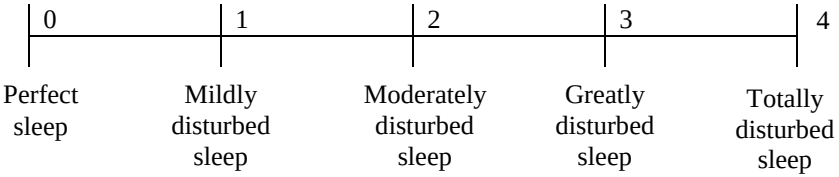
In order to properly assess you condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

Name: _____ **Date**: _____

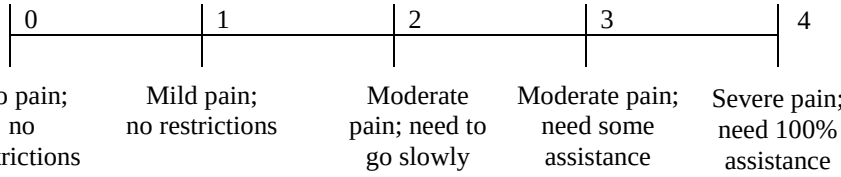
1. Pain Intensity



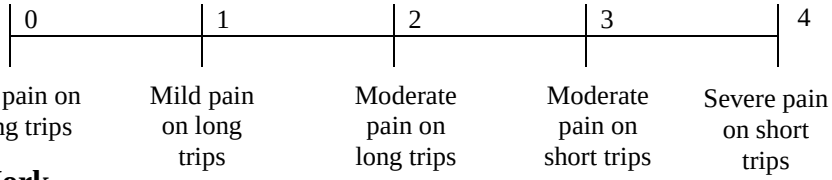
2. Sleeping



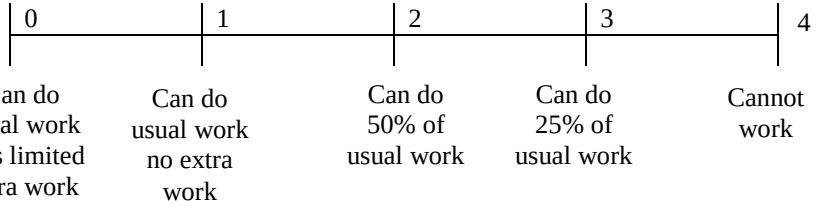
3. Personal Care (washing, dressing, etc)



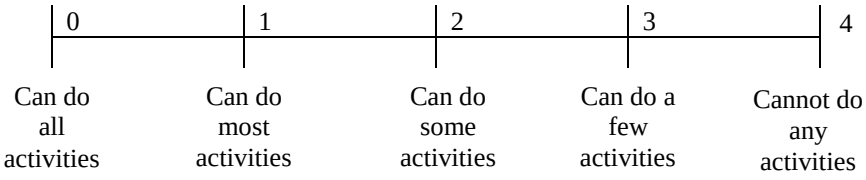
4. Travel (driving)



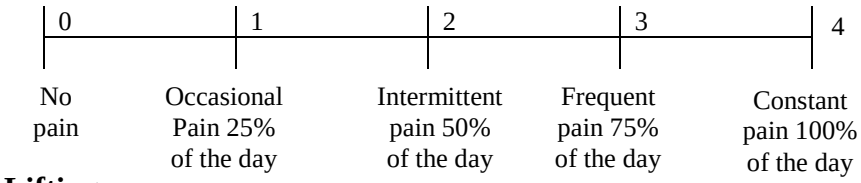
5. Work



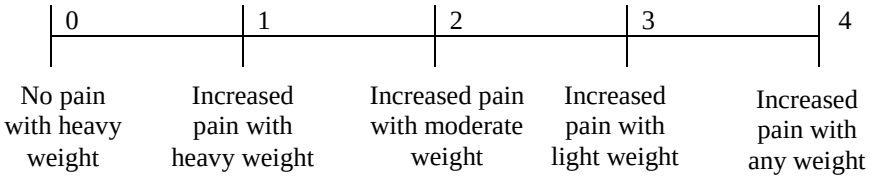
6. Recreation



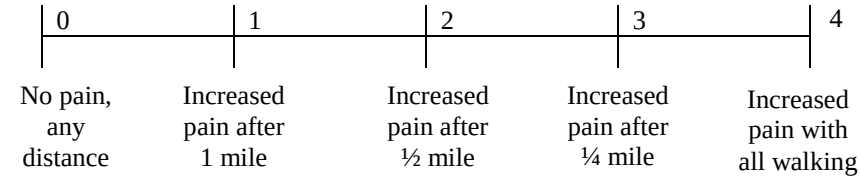
7. Frequency of pain



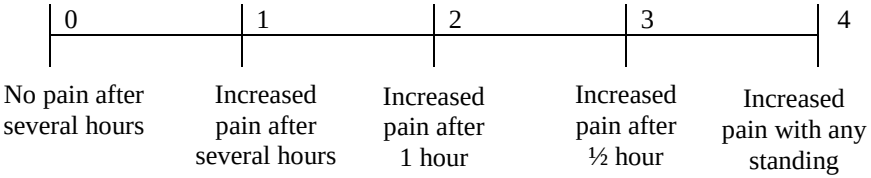
8. Lifting



9. Walking



10. Standing



Total Score: _____

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for care, payment and healthcare operations. For example:

Health Care
We may use or disclose your health information to a physician or other healthcare provider providing care to you.

Payment
We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization
In addition to our use of your health information for your care, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends
We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care
We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

Appointment Reminders
We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Marketing Health-Related Services
We will not use your health information for marketing communications without your written authorization.

Required by Law
We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect
We may disclose your health information to appropriate authorities if we can reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Name: _____

Signature: _____

Date: _____

Luke T. Pavkov, D.C.
Heritage Chiropractic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practices, and our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 4/13/03.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in this Notice.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address in this Notice. If you request copies, we will charge you $0.20 cents for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means, or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the Privacy Officer or with the Office for Civil Rights.

Privacy Officer: Dr. Luke Pavkov

Telephone: 814-796-0077 Fax: 814-796-1717

Address: 18 N Park Row
Waterford, PA 16441

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

This form does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of August 14, 2002. Subsequent law changes may require Form revision.