PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name_____

Address_____

City_____State_____

Zip _____Home phone _____

Birth date _____ Cell Phone_____

Age _____ Gender _____ Number of children _____

Employer _____

Work address _____

Work phone _____

Type of work _____

Marital Status _____

Social Security # _____

E-mail address _____

Payment method ❑ Cash ❑ Check ❑ Credit card

ABOUT THE PARTNER

Name _____

Employer _____

Work phone _____

Type of work _____

HEALTH HABITS

	No	Yes
Do you smoke?	❑	❑
Do you drink alcohol?	❑	❑
Do you drink coffee, tea or soda?	❑	❑
Do you exercise regularly?	❑	❑

Do you wear:

❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to

❑ Job ❑ Sports ❑ Auto ❑ Fall

❑ Home Injury ❑ Chronic Discomfort ❑ Other

Please explain _____

If job related, have you made a report of you accident to your employer? ❑ Yes ❑ No

When did this condition begin? _____

Has this condition

❑ gotten worse ❑ stayed constant ❑ comes and goes

Does this condition interfere with

❑ Work ❑ Sleep ❑ Daily routine ❑ Other activities

Please explain _____

Has this condition occurred before? ❑ Yes ❑ No

Please explain _____

Have you seen other doctors for this condition? ❑ Yes ❑ No

Doctor's Name(s) _____

Type of treatment _____

Results _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you seen or heard about us in/on: ___Paper ___Clinic Sign ___YP

Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No

Reason for those visits? _____

Doctor's name _____

Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? ❑ Yes ❑ No

Has any child in your family seen a Chiropractor? ❑ Yes ❑ No

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

- Doctors of Chiropractic work with the nervous system? ❑ Yes ❑ No
- The nervous system controls all bodily functions and systems? ❑ Yes ❑ No
- Chiropractic is the largest natural healing profession in the world? ❑ Yes ❑ No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ❑ Yes ❑ No

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑ **Relief care** – Symptomatic relief of pain or discomfort

❑ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms

❑ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

❑ I want the Doctor to select the type of care appropriate for my condition.

_____ _____

Patient's signature Date

MEDICATIONS I NOW TAKE

❑ Cholestral medication

❑ Stimulants ❑ Blood thinners

❑ Tranquilizers ❑ Pain killers (including aspirin)

❑ Muscle relaxers ❑ _____

❑ Insulin ❑ _____

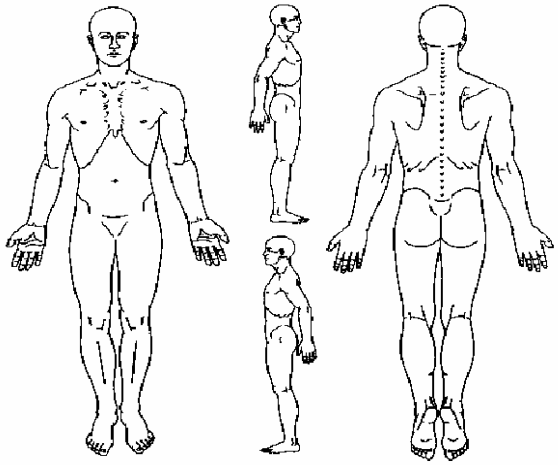
Vitamins & Supplements I now take:_____

_____

_____

_____

_____



N=NUMBNESS **P**=PAIN **T**=TINGLING **ST**=STIFFNESS

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

❑ Severe or frequent headaches
❑ Sinus problems
❑ Dizziness
❑ Loss of sleep
❑ Pain between shoulders
❑ Frequent neck pain
❑ Numbness in Arms/legs/hands
❑ Pain in Arms/legs/hands
❑ Lower back problems
❑ Digestive problems

❑ Heart surgery/ Pacemaker
❑ Heart attack/stroke
❑ Heart murmur
❑ Congenital heart defect
❑ High/Low blood pressure
❑ Difficulty breathing
❑ Asthma
❑ Tuberculosis
❑ Alcohol/drug abuse
❑ Venereal disease
❑ HIV/AIDS
❑ Ulcers/Colitis

❑ Arthritis
❑ Diabetes
❑ Shingles
❑ Kidney problems
❑ Hepatitis
❑ Cancer
❑ Chemotherapy
❑ Rheumatic fever
❑ Psychiatric problems
❑ Thyroid problems
❑ Surgeries
❑ _____
❑ _____

For women:

Are you pregnant? ❑ Yes ❑ No
Are you nursing? ❑ Yes ❑ No
Are you taking birth control? ❑ Yes ❑ No
Do you experience painful periods? ❑ Yes ❑ No
Do you have irregular cycles? ❑ Yes ❑ No
Do you have breast implants? ❑ Yes ❑ No

It is understood and agreed that the payments to the Doctor for X-rays is for examination of x-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office. I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature:_____Date:_____

Name. _____ Date. _____

Effects from Daily Activities

Condition's Effect On Job Performance:

❑ **No Effect** ❑ **Mild** Painful (Can do) ❑ **Mod** Painful (Limited ability) ❑ **Mod/Sev** Limited Duty
❑ **Sev** No Limited Duty ❑ **Sev** Can't Do Limited Duty ❑ **Resolved**

Daily Activities: Effects of Current Condition on Performance

Care-Infirm Family:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Carrying Groceries:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Change Posn-Sit-Stand:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Climb Stairs:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Daily Pet Care:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Driving:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Ext Computer Use:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Household Chores:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Lift Children:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Self Care (Bathing/Dressing):	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Sleep:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Static Sitting:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Static Standing:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Walking:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)
Yard work:	❑ **No Effect**	❑ **Mild Painful** (Can do)	❑ **Mod Painful** (Limited ability)	❑ **Severe** (Unable to Perform)

Review of Systems - Please fill out all sections even if "None"

Constitutional: ❑ Chills ❑ Daytime Somnolence ❑ Fatigue ❑ Fever ❑ Night Sweats ❑ Weight Gain
❑ None ❑ Weight Loss

Eyes/Vision: ❑ Blindness ❑ Blurred Vision ❑ Cataracts ❑ Change in Vision ❑ Double Vision ❑ Eye Pain
❑ None ❑ Field Cuts ❑ Glasses/Contacts ❑ Glaucoma ❑ Itching ❑ Photophobic ❑ Tearing

ENT: ❑ Bleeding ❑ Dentures ❑ Dizziness ❑ Discharge ❑ Difficulty Swallowing ❑ Frequent Sore Throats
❑ None ❑ Ear Pain ❑ Fainting ❑ Headaches ❑ Ear Drainage ❑ Hearing Loss ❑ History of Head Injury
❑ Hoarseness ❑ Loss of Smell ❑ Nasal Congestion ❑ Nose Bleeds ❑ PND (Post Nasal Drip) ❑ Runny Nose
❑ Sinus Infection ❑ Snoring ❑ TMJ ❑ Tinnitus (Ringing in Ears)

Respiration: ❑ Asthma ❑ Cough ❑ Coughing up Blood ❑ Sputum Production ❑ Wheezing ❑ Shortness of Breath
❑ None

Cardio: ❑ Angina ❑ Chest Pain ❑ Claudication ❑ Heart Murmur ❑ Heart Problems ❑ Orthopnea
❑ None ❑ Palpitations ❑ PND ❑ SOB with Exertion ❑ Swelling of Legs ❑ Varicose Veins

Gastro: ❑ Abdominal ❑ Belching ❑ Black Tarry Stools ❑ Constipation ❑ Diarrhea ❑ Difficulty Swallowing
❑ None ❑ Heartburn ❑ Hemorrhoids ❑ Indigestion ❑ Jaundice ❑ Nausea ❑ Rectal Bleeding
❑ Stool Caliber ❑ Stool Color ❑ Stool Consistency ❑ Vomiting ❑ Vomiting Blood

Female: ❑ Breast Lumps/Pain ❑ Burning Urination ❑ Cramps ❑ Frequent Urination ❑ Vaginal Discharge ❑ Irregular Menstruation
❑ None ❑ Urine Retention ❑ Vaginal Bleeding

Male : ❑ Burning Urination ❑ Erectile Dysfunction ❑ Frequent Urination ❑ Hesitancy/Dribbling ❑ Prostate ❑ Urine Retention
❑ None

Endocrine: ❑ Cold Intolerance ❑ Diabetes ❑ Excessive Appetite ❑ Excessive Hunger ❑ Excessive Thirst ❑ Frequent Urination
❑ None ❑ Goiter ❑ Hair Loss ❑ Heat Intolerance ❑ Unusual Hair Growth ❑ Voice Changes

Skin: ❑ Changes in Skin Color ❑ Hair Growth ❑ Hair Loss ❑ Hives ❑ Itching ❑ Changes in Nail Texture
❑ None ❑ Parestesia ❑ Rash ❑ Skin Lesions/Ulcers ❑ Varicosities ❑ History of Skin Disorders

Nervous: ❑ Dizziness ❑ Facial Weakness ❑ Headache ❑ Limb Weakness ❑ Loss of Memory ❑ Loss of Consciousness
❑ None ❑ Numbness ❑ Seizures ❑ Sleep Disturbance ❑ Slurred Speech ❑ Stress ❑ Strokes
❑ Tremor ❑ Unsteadiness of Gait

Psychologic: ❑ Anhedonia ❑ Anxiety ❑ Appetite Change ❑ Behavior Change ❑ Bipolar ❑ Confusion
❑ None ❑ Depression ❑ Insomnia ❑ Memory Loss ❑ Mood Change

Allergy: ❑ Anaphylaxis ❑ Food Intolerance ❑ Itching ❑ Nasal Congestion ❑ Sneezing
❑ None

Hematology: ❑ Anemia ❑ Bleeding ❑ Blood Clotting ❑ Blood Transfusions ❑ Bruising ❑ Fatigue
❑ None ❑ Lymph Node Swelling

Paci Chiropractic, Inc.
Attilio A. Paci, D.C.
"Promoting Good Health Naturally"

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____ _____

Patient Name (printed) Relationship to patient

_____ _____

Patient or legal Guardian (signature) Date

_____ _____

Witness Signature (office staff) Date

200 Northern Avenue Hagerstown, MD 21742
Phone: (301)-733-4445 Fax: (301)-733-3383
www.pacichiropractic.com

Paci Chiropractic, Inc.
200 Northern Ave.
Hagerstown Md. 21742
301-733-4445

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:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____ Pulse:_____

PACI CHIROPRACTIC, Inc.
200 Northern Avenue
Hagerstown, MD 21742

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____