NEW PATIENT INFORMATION

DATE_____

FIRST NAME_____MI___LAST NAME_____

ADDRESS_____APT#_____

CITY_____STATE_____ZIP_____

PRIMARY PHONE_____HOME PHONE_____CELL_____

BIRTHDATE_____ SEX_____F_____M

____SINGLE____MARRIED____DIVORCED____WIDOW____SEPARATED

EMPLOYER_____OCCUPATION_____PHONE_____

MEDICARE#_____

IF PATIENT IS A MINOR:

FATHER'S NAME_____PHONE#_____

MOTHER'S NAME_____PHONE#_____

GUARDIAN_____PHONE#_____

PARENT SIGNATURE TO TREAT A MINOR: _____

PRIMARY COMPLAINT(S) _____

ARE YOUR PRESENT PROBLEMS DUE TO AN INJURY? _____YES____NO

_____ON THE JOB____AUTO ACCIDENT____PERSONAL INJURY

DO YOU HAVE A PAST HISTORY OF ANY SERIOUS INJURIES OR ILLNESS? ____YES____NO

EXPLAIN_____

REFERRED BY_____

PATIENT HEALTH QUESTIONNAIRE

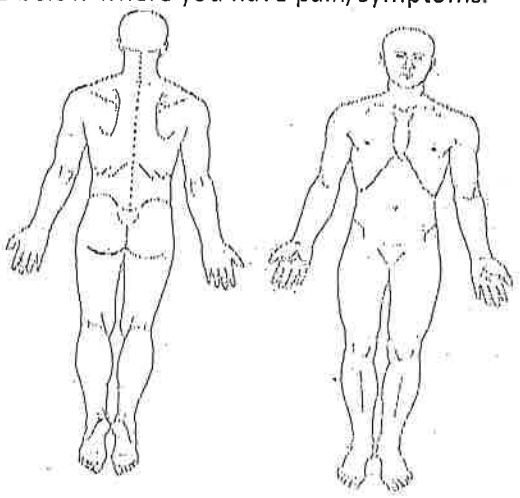
Patient Name: _____ DOB _____

Date your symptoms started: _____ Describe your symptoms and accident/illness:

_____

_____

How often do you experience your Symptoms? Indicate below where you have pain/symptoms.



____ CONSTANTLY
____ FREQUENTLY
____ OCCASIONALLY
____ INTERMITTENTLY

What best describes the symptoms/pain?

____ SHARP ____ SHOOTING
____ DULL ACHE ____ BURNING
____ NUMB ____ TINGLING

What tests have you had performed?

____ XRAYS date: _____
____ MRI date: _____
____ CT SCAN date: _____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

For each of the conditions listed below, please place a check.

____ HEADACHES
____ NECK PAIN
____ UPPER BACK PAIN
____ MID BACK PAIN
____ LOW BACK PAIN
____ SHOULDER PAIN
____ ELBOW/UPPER ARM PAIN
____ WRIST PAIN
____ HAND PAIN
____ HIP/UPPER LEG PAIN
____ KNEE/LOWER LEG PAIN
____ ANKLE/FOOT PAIN
____ JAW PAIN
____ DIZZINESS

LIST OF MEDICATIONS:

_____

_____

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

Patient Health Questionnaire - page 2

Patient Name _____ ***Date*** _____

Play any sports? ☐ ***Yes*** ☐ ***No*** ***What sports?*** _____

Ever broken a bone? ☐ ***Yes*** ☐ ***No*** ***What bones?*** _____ ***Knocked out?*** ☐ ***Yes*** ☐ ***No***

Falls as a child? ☐ ***Yes*** ☐ ***No*** ***Explanation:*** _____

Motor vehicle accidents? (*please note type and year, even if not apparently injured*) _____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/Use Tobacco Products
						☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones			
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
			☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain				☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			
			☐	☐	Loss of Appetite	***Females Only***		
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			
			☐	☐	Ulcer	☐	☐	Birth Control Pills
☐	☐	Joint Swelling/Stiffness	☐	☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis				☐	☐	
			☐	☐	Cancer			
☐	☐	General Fatigue	☐	☐	Tumor	***Other Health Problems/Issues***		
☐	☐	Muscular Incoordination	☐	☐	Asthma	☐	☐	
☐	☐	Visual Disturbances	☐	☐	Chronic Sinusitis	☐	☐	
☐	☐	Dizziness				☐	☐	

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor 's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

Authorization Form
Release of
Protected Health Information

Clark Chiropractic Clinic, PC
6301 Eastridge Rd.
Odessa, Texas 79762

We are required by law and regulations to protect the privacy of your medical information. Without this form signed by patient, or an agent given medical power of attorney, your private health information and/or treatments will not be disclosed.

By signing this form, I authorize you to use and disclose the protected health information described below.

The health information you may release subject to this authorization is as follows:

___Medical ___Financial ___Other:_____

Release my protected health information to the following person (s)/entity:

Name: _____Relation_____Phone:_____

Name: _____Relation_____ Phone: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Privacy Officer: Clark Chiropractic Clinic, PC 6301 Eastridge Rd. Odessa, Texas 79762

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____ _____
Signature of Patient Date of Birth Date

_____ _____
Signature of Personal Representative Relationship to Patient (or other authority)

Acknowledgement of Receipt of Notice and Consent to use and Disclose Health Information Please read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Clark Chiropractic Clinic, PC to use and disclose health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices: Clark Chiropractic Clinic, PC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.
Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a written request to our Privacy Officer.
Consent to Treatment: I voluntarily consent to receive medical and health care services provided by Clark Chiropractic Clinic, PC, employees and such associates, assistants, and other care providers. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, digital and/or other images may be made/recorded for treatment and payment purposes only.

I acknowledge that Clark Chiropractic Clinic, PC may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but not limited to, treatments, labs, medical history, and other health care information.

Please mark if you agree to accept artificial messages by:

Phone Calls ___Yes ___No Text Messages ___Yes ___No Cell #/Carrier_____

Email ___ Yes___ No Email Address_____

How to contact our Privacy Officer: Clark Chiropractic Clinic, PC 6301 Eastridge Rd. Odessa, TX 79762 Telephone: (432) 337-5553 Facsimile: (432) 337-6183

Acknowledgement and Consent: Clark Chiropractic Clinic, PC is authorized to use and disclose health information about the patient listed below for treatment, payment, and other health care operations purpose consistent with its Notice of Privacy Practice.

I have reviewed the Notice of Privacy Practice for Clark Chiropractic Clinic, PC:

_____
Print Name (Patients)

_____ _____

Signature of Patient or Representative **Date**

Clark Chiropractic Clinic, PC
6301 Eastridge Rd.
Odessa, Texas 79762
(432) 337-5553

Clark Chiropractic Clinic, PC reserves the right to modify the privacy practice outlined in the notice:

☐ I have received a copy of the notice of privacy for Clark Chiropractic Clinic, PC

_____

Name of Patient (Please Print):

_____

Signature of Patient:

_____

Signature of Representative:

_____

Required if the patient is a minor or an adult who is unable to sign this form.

Relationship of Patient Representative to patient

_____

Date:

_____

Clark Chiropractic Clinic, PC
6301 Eastridge Rd.
Odessa, Texas 79762
(432) 337-5553

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Clark Chiropractic Clinic, PC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Clark Chiropractic Clinic, PC Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.

The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect

or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office staff or Privacy Officer . Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office for Civil
Rights, U.S.
Dept. of
Health and
Human
Services,
200
Independence
Ave. SW
Washington,
DC 20201

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is:

Dr. JW Kirk, DC

Clark Chiropractic Clinic, PC

6301 Eastridge Rd.

Odessa, Texas 79762

(432) 337-5553

October 21, 2013

This notice is effective on or after October 21, 2013