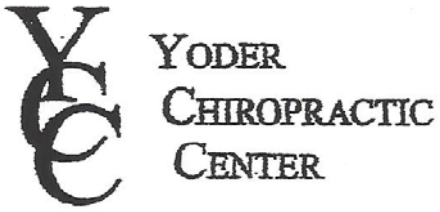


NAME: First_____ MI_____ Last_____

DOB: ____/____/____ Marital Status: ___M ___S ___D ___W Gender: ___M ___F

Mailing Address:_____ City:_____ State:_____

Zip:_____ Home Phone:(____) _____ Cell Phone:(____) _____

Employment Status: ___Employed ___Retired ___Student Occupation: _____

Employer: _____ Work Phone: (___) _____

Spouse's Name/Emergency Contact: _____ Phone: _____

How did you hear about our office? ___Patient ___Yellow Pages ___Sign Other:_____

Would you like to receive appointment reminders through e-mail? ___Yes ___No

If yes, what is your e-mail address? _____

Would you like to receive appointment reminders through text message? ____Yes ____No

If yes, who is your cell phone carrier? _____

Medical Conditions:_____

Allergies:_____

Current Medications:_____

REQUIRED FOR INSURANCE:

Smoker: ___Yes ___No **If yes, how many packs per day**?_____ **How long**?_____

Race: ___American Indian or Alaskan Native ___Asian ___Black/African American ___White

___Hispanic or Latino ___Native Hawaiian or Pacific Islander ___Decline to Answer ___Unknown

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Decline to Answer

Primary Language: ___English ___Spanish Other: _____

I voluntarily consent to receive chiropractic and health care services that include diagnostic procedures, examination, physical therapy, and treatment. I understand and agree that I am responsible for the payment of any services rendered at the time of service. I understand that insurance policies are an arrangement between the insurance carrier and myself and may not cover all services rendered for care. I understand that *Yoder Chiropractic Wellness Center* may assist in preparation and submission of insurance claims, and, if so, that any amount authorized to be paid to *Yoder Chiropractic Wellness Center* will be credited to my account.

Patient/Guardian Signature:_____ **Date**:_____

PATIENT: _____ DATE: _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

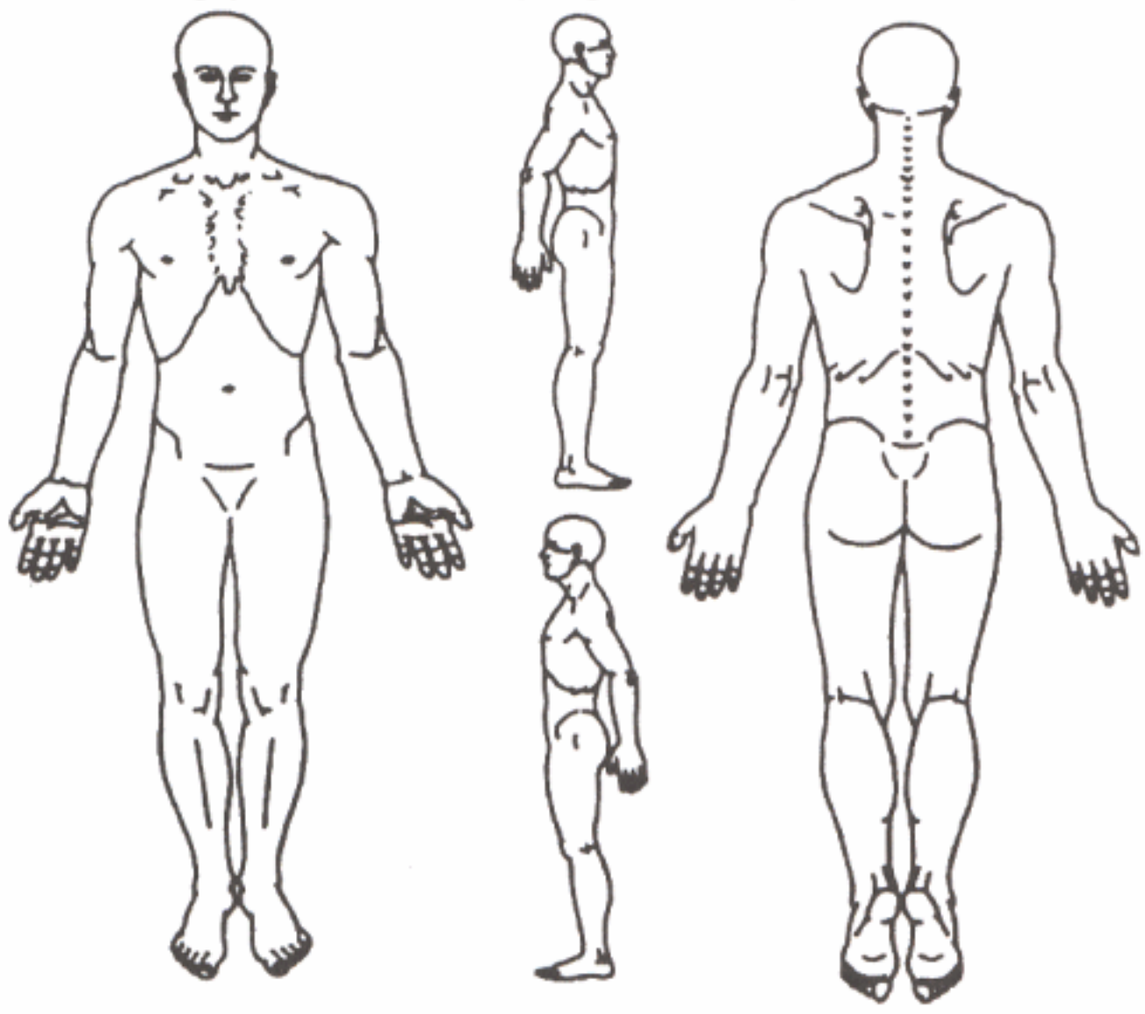
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

	Occasional		*Intermittent*		*Frequent*			*Constant*		
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? ❑ Yes ❑ No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates?_____ to _____
12. Are you Pregnant? ❑ Yes ❑ No Date Due _____
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____
standing ____
social life ____

Signature:_____

Date: ____/____/____

STATEMENT OF PRIVACY—Yoder Chiropractic Wellness Center

It is the policy of our practice that all doctors and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its doctors and staff have necessary medical information and PHI to provide the highest quality care possible, while protecting the confidentiality of the PHI of our patient to the highest degree possible. Our practice and its doctors and staff will:

-adhere to the standards set forth in the Notice of Privacy Practice;

-collect, use, and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorization, as appropriate. Our practice and its doctors and staff will not use or disclose PHI for uses outside of the practice's treatment, payment, and healthcare operations (TPO), such as marketing, employment, life insurance applications, etc. without an authorization from the patient;

-use and disclose PHI to remind patient of their appointments unless they instruct us not to;

-recognize the PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and doctors and staff will implement reasonable measures to protect the integrity of all PHI maintained;

-recognize that patients have a right to privacy. Our practice and its doctors and staff respect the patient's individual dignity at all times and will respect the patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility;

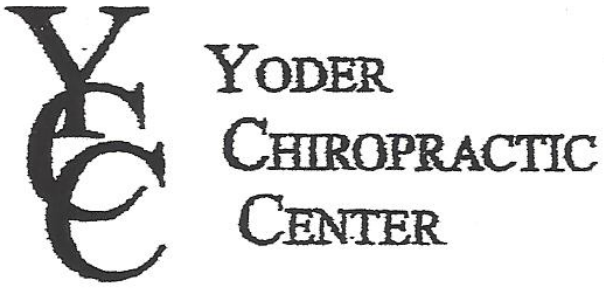
-act as responsible information stewards and treat all PHI as confidential. Consequently, our practice and doctors and staff will: treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements; not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release;

-recognize that, although our practice "owns" the medical records, the patient has the right to obtain a copy of his/her PHI. In addition, the patient has the right to request an amendment to his/her records if he/she believes his/her information is inaccurate or incomplete. Our practice and its doctors and staff will: permit patient access to their medical records when their written requests are approved by our practice. If we deny their request, we must inform that patient that they may request a review of our denial. In such cases, we will have an on site healthcare professional review the patient's appeal; provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards;

-maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA. We will provide this list to patients on written request;

-adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice;

- adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personal rules and regulations.



The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provide privacy protections to your medical records. Our office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under your group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information to.

____You may discuss my medical information with the following person(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

____Please do not discuss my medical information with anyone.

I have read and understand the Statement of Privacy as given to me. I understand that this form will be placed in my patient chart and will be maintained for the life of my patient records. I also understand that, if there are any changes to this authorization, I will submit them in writing.

Patient/Guardian Signature:_____ Date:_____