INTEGRATIVE HEALING ARTS

ANNE C. ROULO, DC

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314.644.2070

Date_____

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Social Security Number:_____-_____-_____

Home Phone: (___)_____ Cell Ph.: (___)_____Work Ph.: (___)_____

Gender: M F Date of Birth:_____ Age:_____

Marital Status: S M D W Work Status: Full time Part time Retired

# of Children_____

Employer:_____ Occupation:_____

Employer Address: _____

City: _____ State:_____ Zip:_____

Name of Spouse or Partner. For Minors, Name of Parent or Guardian:

_____

Age:_____ Employer:_____ Occupation:_____

Employer Address: _____

City: _____ State:_____ Zip:_____

Work Phone:(___)_____

In case of emergency contact:_____

Relationship:_____

Do you have Medicare insurance? Y N Plan/Group #:_____

List chiropractors you have seen previously _____

How did you find us, and may we thank someone for referring you? _____

_____

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my PHI will be used and I agree to these policies and procedures:

Signature:_____ Date:_____

(Medicare Patients Only) Waiver of Liability/Advance Beneficiary Notice
Includes <u>all</u> services.

Provider Notice: Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

Beneficiary Agreement: "I have been notified by my provider that he/she believes that Medicare may deny payment for service. If Medicare denies payment, I agree to be personally and fully responsible for payment".

Signature:_____ Date:_____

I understand that payment is due in full at time of service unless prior arrangements have been made. Fees are based on upon individual services and may vary from visit to visit.

I agree to pay in full at the time of service and will file my own insurance. Reimbursement is determined by my contract with my insurance company.

Signature:_____ Date:_____

Health History:

Habits:

	Drinks/day
Alcohol	_____
Soda/diet soda	_____
Coffee/tea	_____
Sweetener	_____

Water intake (per day) □ 64+ oz □ 32-64 oz □ 16-32 oz □ 8-16 oz □ < 8 oz

1 glass = 8-12 oz

Tobacco: Packs/day _____

Stress level: □ High □ Mod □ Low

Sleep: □ 8+ hrs □ 6-8 hrs □ 4-6 hrs □ < 4 hrs

Exercise: □ 5-7x/wk □ 3-5x/wk □ 1-3x/wk □ none Type_____

Meals/day: □5 □4 □3 □2 □1

Veggies and fruits/day: □5 □4 □3 □2 □1

-Do you feel your diet is adequate? □Y □N

-Has your diet affected your quality of life? □Y □N

-Are you on a special diet or particular diet? □Y □N If yes explain _____

-How long has it been since you felt really good? □ Days □ Weeks □ Months □ Years □ >10 years

-What is your general state of health? □ Excellent □ Good □ Fair □ Poor

-Please rate how serious you are about getting well (scale of 1 -10) _____

-Please rate how serious you are about staying well (scale of 1 -10) _____

-Are you willing to follow a treatment plan designed to help you return to health? □ Yes □ No

-Are you willing to take supplements and make dietary changes? □ Yes □ No

Work Activity:

□ Heavy labor □ Light Labor □ Mostly Sitting □ Mostly Standing □ Driving □ Walking

Medications: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
□ Antacids	_____	_____
□ Antibiotics	_____	_____
□ Anti-depressants	_____	_____
□ Anti-diabetics	_____	_____
□ Anti-inflammatory	_____	_____
□ Blood pressure lowering meds	_____	_____
□ Cholesterol lowering meds	_____	_____
□ Hormone Replacement (HRT)	_____	_____
□ Oral contraceptives	_____	_____
□ Over-the-Counter	_____	_____
□ Other	_____	_____
□ Other	_____	_____

Do you take vitamins/supplements or herbs? □Y □N

Please list:_____

_____

Allergies: Please list all allergies.

□ Food:_____

□ Medications:_____

□ Seasonal/Other:_____

Surgical Procedures/Scars: List all major surgeries, date performed, and scar location._____
_____
_____

Hospitalizations: Describe reason for hospitalization, date, and treatment. _____
_____

Automobile Accidents: List date, injuries, and treatment._____
_____
_____

Other Accidents: Describe accident (eg. fractures, dislocations, bad falls, sprains, head injuries)._____
_____
_____

Please give the most recent date: Lab work: _____ Radiographic study and body part: _____
Physical exam: _____ Females: Pap smear and breast exam: _____

Please mark with an "S =self" any illnesses that you have now or have had in the past. Also, identify any conditions your family members have now or have had in the past. G = Grandparents, M = Mother, F = Father.

___ Arthritis
___ Blood pressure problems
___ Heart disease
___Anemia or other blood disorder
___ Diabetes or hypoglycemia
___ Kidney disease
___ Bladder problems
___ Gall bladder problems
___ Hepatitis
___ Colon disease
___ Ulcers
___ Headaches
___ Emphysema
___ Gout
___ Asthma
___ Pneumonia
___ Tuberculosis
___ Muscle disorders
___ Neurological Problems
___ Immune system problems
___ Tumors: non-cancerous
___ Cancer
___ HIV/AIDS
___ Anxiety
___ Cold sores
___ Alcoholism
___ Drug Abuse
___ Deep vein thrombosis
___ Epilepsy
___ Stroke
___ Osteoporosis

Symptoms: Please mark “P” (past) or “C” (current), and circle any that are of particular concern to you.

General
___ Convulsions
___ Confusion
___ Dizziness
___ Fatigue
___ Loss of sleep
___ Loss of weight
___ Nervousness
___ Numbness
___ Sweats
___ Weakness in limbs
___ Fever

Muscles and Joints
___ Twitching
___ Stiff Neck
___ Backache
___ Swollen Joints
___ Tremors
___ Foot Trouble
___ Painful Tailbone
___ Pain between Shoulders
___ Hernia
___ Spinal Curvature

Gastro-intestinal
___ Poor Appetite
___ Poor Digestion
___ Excessive Hunger
___ Belching
___ Foul Gas
___ Nausea
___ Vomiting
___ Vomiting or Blood

Women Only
___ Painful Periods
___ Excessive Flow
___ Irregular cycle
___ Hot Flashes
___ Cramps or Backache
___ Miscarriage
___ Vaginal Discharge
___ Fertility Problems
Pregnant? □ Yes □ No
Nursing? □ Yes □ No

___ Pain Over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids
___ Liver Trouble
___ Jaundice
___ Gall Bladder Trouble

Cardiovascular
___ Rapid Heart
___ Slow Heart
___ High Blood Pressure
___ Low Blood Pressure
___ Pain over Heart
___ Stroke
___ Poor Circulation
___ Ankle Swelling
___ Hardening of Arteries

EENT
___ Poor Vision
___ Crossed Eyes
___ Pain in Eyes
___ Deafness
___ Earache
___ Ear Noises
___ Ear Discharge
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throats
___ Horseness
___ Hay Fever

___ Asthma
___ Frequent Colds
___ Enlarged Thyroid
___ Tonsillitis
___ Sinus Trouble

Skin
___ Skin Eruptions
___ Itching
___ Bruise Easily
___ Dryness
___ Boils
___ Sensitive Skin
___ Eczema
___ Varicose Veins

Respiratory:
___ Chronic Cough
___ Spitting Blood
___ Spitting Phlegm
___ Chest Pain
___ Difficulty Breathing

Genito-urinary
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Infection
___ Bed Wetting
___ Inability to control urine
___ Prostate trouble
___ Decreased Libido

Health Concerns: Please list your top health concerns in order of priority.
1._____
2._____
3._____

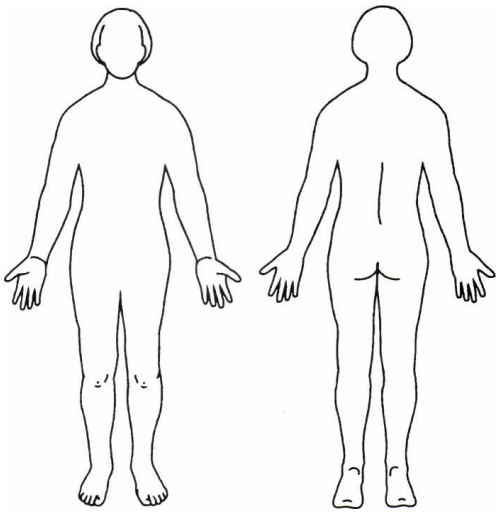
What type of treatment are you looking for? Please check all that apply.

□ I am looking for the most minimal amount of care to "patch up" the symptoms of my condition.
□ I am looking to resolve my symptoms, and then go on to address the cause of my condition.
□ I am looking to resolve my symptoms, achieve optimal health, wellness, and disease prevention.

Please check all that apply:
□ I have a health condition, I am concerned and I don't know what it is.
□ I have a medical condition and am receiving medical treatment and am unhappy with my results.
□ I have a medical condition and wish to enhance my medical treatment.
□ I have been to other doctors and/or chiropractors and continue to have health problems and wish to see if Dr. Roulo's approach will help me.
□ I am currently on medications/drugs and wish to get off them.
□ If yes, have you suggested this to the prescribing physician?
□ I am currently on medications/drugs and wish to stay on them.
□ I wish to discontinue medical treatment and am seeking an alternative method.
□ I wish to be examined and evaluated from a holistic "total person" approach where my mental, structural, and physiologic systems are included in the treatment of my health or health conditions.

Primary Concern:

Location and severity of pain:
Indicate the location and type of pain on the drawing using the following symbols: Dull xxxxx Cramping ///// Sharp/stabbing ••••• Burning 00000 Tingling ///// Numbness +++++



On a scale of 1 to 10, with 1 representing minimal pain, and 10 representing unbearable pain, how would you rate your pain?_____

-Is your concern a result from: □ an auto accident? □ an injury at work? □ another accident?
-Has another doctor treated you for this condition? □Y □N When?_____
-Type of treatment_____
-Is this condition interfering with your: □ Work □ Sleep □ Daily Routine □ Recreation
□ Other: _____
-What do you believe is wrong with you? _____

-Since your symptoms began, have you noticed a change in?
Bowel function □Yes □No
Bladder function □Yes □No
Sexual function □Yes □No

Headaches:
If you are experiencing headaches, please fill out this section. Otherwise it can be skipped.
-What seems to bring on your headaches? Circle all that apply
Physical Activity Excessive Stress Alcohol Caffeine Certain Foods
Menstrual Period Other _____
What date did your headaches begin? / /
-How often do they occur? Time/week _____ Times/month _____ Other_____
-How long do they last? Less than an hour 1-3 hours Longer than 3 hours
All waking hours Several hours to days Other_____
-Do you headaches wake you from sleep? No Sometimes Always
-Do any of the following occur with your headaches? Circle all that apply
Nausea/vomiting Weakness Tremor Dizziness Vision problems
Light/Sound sensitivity Other_____

-What makes your headaches better? Circle all that apply
Nothing Rest Lying down Ice/Cold packs Massage Standing
NSAIDS(aspirin, tyelonol) Medication Other_____
-When do you headaches usually start? Circle all that apply Constant/Anytime awake Midday
Upon waking up in the morning During the evening
-What describes your pain? Circle all that apply
Burning Dull Sharp Shooting Aching Throbbing
Deep Vice-Like Other _____
-How would you rate your overall headache None 0 1 2 3 4 5 6 7 8 9 10