POWER
CHIROPRACTIC HEALTH

Personal Information

Name: _____ Birth Date ___/___/___ Age _____

Address: _____ Home Phone: _____

City _____State _____Zip _____ Cell Phone: _____

Work Phone: _____ Cellular Provider: _____

Email Address: _____Work Email: _____

Occupation: _____ Employer's Name _____

Married/ Widowed/ Divorced Last 4 digits of Social Security # _____

Spouse's Name _____ Spouse's Employer _____

Number of Children: _____

Names, Ages, & Gender of Children_____

Who can we thank for referring you to our office? _____

In Case of Emergency

Emergency Contact Name: _____

Phone Number: _____Relationship: _____

List The Health Concerns That Brought You Into This Office

	Health Concern: List according to Severity	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Are symptoms Constant or Intermittent?
Primary:	_____	_____	_____	_____	_____
Second:	_____	_____	_____	_____	_____
Third:	_____	_____	_____	_____	_____
Fourth:	_____	_____	_____	_____	_____

Please check any of the following that have given you difficulty in the last year:

General

- ☐ Headaches
- ☐ Shooting Head Pain
- ☐ Loss of Memory
- ☐ Fatigue
- ☐ Depression
- ☐ Dizziness
- ☐ Thyroid Trouble
- ☐ Chills
- ☐ Sweats
- ☐ Sleeping Problems
- ☐ Seizures
- ☐ Fainting
- ☐ Irritability
- ☐ Nervousness
- ☐ Inner Tension
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Twitching of face
- ☐ Facial Pain
- ☐ TMJ (Jaw Pain)
- ☐ Menstrual Cramps/ Pain
- ☐ Menstrual Irregularity
- ☐ Loss of Balance
- ☐ Prostate Trouble
- ☐ Infertility
- ☐ Scoliosis
- ☐ Shortness of Breath
- ☐ Hernia
- ☐ Arthritis
- ☐ Diabetes
- ☐ Painful Joints
- ☐ Swollen Joints
- ☐ Ulcers
- ☐ Cancer

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Sores that won't heal

Gastrointestinal

- ☐ Bowel Changes
- ☐ Intestinal Gas
- ☐ Constipation
- ☐ Indigestion
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting Blood
- ☐ Gall Bladder Trouble
- ☐ Hemorrhoids
- ☐ Diarrhea

Cardiovascular

- ☐ Anemia
- ☐ Chest Pain
- ☐ Heart Attacks
- ☐ Stroke
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ Irregular Heart Beat
- ☐ Rapid Heart Beat
- ☐ Swollen Ankles

Eye/ Ear/ Nose &Throat

- ☐ Loss of Hearing
- ☐ Earache
- ☐ Sinus Trouble
- ☐ Loss of Smell
- ☐ Allergies
- ☐ Hay Fever
- ☐ Asthma
- ☐ Loss of Taste
- ☐ Inflammation of Throat
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Tonsillitis
- ☐ Blurred Vision
- ☐ Sensitivity to Light

Neck

- ☐ Neck Pain
- ☐ Pinched Nerve in neck
- ☐ Muscle Spasms in neck

Shoulders

- ☐ Shoulder/ arm pain
- ☐ Pain across shoulders
- ☐ Can't raise arms
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulders

Arms/Hands

- ☐ Numbness/tinglin in arms/hands
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Pain in wrist
- ☐ Pain in hand
- ☐ Pain in fingers
- ☐ Weakness of hand
- ☐ Cold hands

Mid Back

- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back
- ☐ Low-back pain
- ☐ Low-back feels out of place
- ☐ Muscle spasms in low-back

Legs/Feet

- ☐ Cold feet
- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Pain down leg
- ☐ Pain in knee
- ☐ Pain in ankle
- ☐ Pain in foot
- ☐ Weakness of leg
- ☐ Weakness of knee
- ☐ Leg cramps
- ☐ Numbness in legs/feet

Please describe your primary health concern:

_____

Have you had previous chiropractic care? Y/N _____ When? _____Reason for initial visit: _____

How long did you receive care? _____ How often did you go? _____

Medical Doctor Name _____ Phone Number _____

Women Only: Are you pregnant? Y/N _____ Due Date: _____ Last Menstrual Period: _____

Medications: Are you taking any medications? Y/N (If yes, name the medications, frequency, and dosage)

_____

_____

_____

What side effects have you experienced from these drugs? _____

Have you had surgery? Y/N Reason: _____Date: _____

Accident History: Within the past year: (Date and Describe) _____

Over a year ago: (Date and Describe) _____

Hospitalizations: (Date and Describe) _____Birth Trauma? Y/N _____

Vaginal or cesarean delivery for YOUR birth?

_____

Social History

Smoking: How often? ___ Daily ___Weekends ___ Occasionally ___ Never

Alcohol: How often? ___ Daily ___Weekends ___ Occasionally ___ Never

Exercise: How often? ___ Daily ___Weekends ___ Occasionally ___ Never

Have you consumed any caffeine or products with caffeine in the past 48 hours? ___ Yes ___ No

To better serve you in our office, please check any of the conditions below that you or your family have or have had in the past:

	Yourself	Spouse	Children	Father	Mother
Acid Reflux					
ADHD					
Allergies					
Anxiety					
Arthritis					
Asthma					
Autoimmune problems					
Bed wetting					
Cancer					
Constipation					
Depression					
Diabetes					
Dizziness					
Ear Infections					
Eczema					
Fatigue					
Flu					
Headaches					
Heart problems					
Immune problems					
Indigestion					
Infertility					
Kidney problems					
Liver problems					
Menstrual problems					
Migraines					
Nausea					
Numbness					
Sciatica					
Scoliosis					
Seizures					
Sinus problems					
Stiffness					
Stomach trouble					
TMJ pain					
Ulcers					
Vertigo					
Other (Please explain)					

Name _____ Date _____

Dr. Karl Baune
Power Chiropractic Health
P 559-765-4164
www.getpowerchiropractic.com

HIPPA NOTICE OF PRIVACY PRACTICES

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. This Notice of Privacy Practices describes Power Chiropractic Health (PCH) may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your physician, PCH office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of PCH, and other use required by law.

TREATMENT: PCH will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, PCH would disclose your PHI, as necessary, to a home health agency that provides care to you, or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your PHI will be used, as needed, to obtain payment from your insurance company for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: PCH may use or disclose, as needed, your protected health information in order to support the business activities of PCH. These activities include, but are not limited to: (a) quality assessment activities; (b) employee review activities; (c) training of medical students; and (d) licensing and conducting or arranging for other business activities. For example, PCH may disclose your PHI to medical school students that see patients at the office. In addition, PCH may use a sign-in sheet at the registration desk where you will be asked to sign your name, may call you by name in the waiting room when your physician is ready to see you, may use or disclose your PHI as necessary to contact you to remind you of your appointment by leaving a message on a recorded answering system at your home of office or by text messaging.

At PCH, it is the practice of this office to provide chiropractic care in a "semi-closed" environment. "Semi-closed" adjusting involves patient care in a setting where other patients in the reception area are able to see into the adjusting rooms, as well as possibly hear what is being discussed in the adjustment room. This environment is used for ongoing care and is NOT used for initial examination and patient history consultation. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosure" of health information. I accept and agree to being treated in this "semi-closed" environment and understand the potential risk for incidental disclosure and do not hold PCH liable for such actions.

- **I give Power Chiropractic Health permission to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.**
- **If Power Chiropractic Health contacts me by phone, I give them permission to leave a message on my voice mail or answering machine.**
- **I give Power Chiropractic Health permission to use my name and picture on the welcome board, referral board, birthday board, prize winning notices, and community information, (i.e. newspaper clippings, practice member testimonials) and social media postings regarding your progress of care.**
- **I give Power Chiropractic Health permission to adjust me in a semi-closed room setting where other patients and office staff may be able to overhear some of my PHI during care. This semi-closed room environment is used for ongoing care, and is not the environment used for taking patient histories, performing examinations, or presenting report of findings, as these procedures are completed in a private, confidential setting.**

PCH may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law; public health issues; communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroner; funeral directors, organ donation; research; criminal activity; military activity, National security; workers' compensation, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS:

Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. However, in accordance with federal law, you may not inspect and copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction or your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state specific restrictions requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice in an alternative medium, such as electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

If you believe that Power Chiropractic Health has violated your privacy rights, you may file a complaint with Karl Baune, D.C. at Power Chiropractic, or you can file a complaint with the Secretary of Health and Human Services, at 200 Independence Avenue SW, Washington DC 20201.

I have read, understand and agree to the aforementioned HIPPA regulations. Signature (parent/guardian, when applicable)

Signature _____ **Date** _____

Dr. Karl Baune
Power Chiropractic Health
P 559-765-4164
www.getpowerchiropractic.com

TERMS OF ACCEPTANCE/ CONSENT TO TREATMENT

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 used 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 physical, mental and social well-being; not merely the absence of disease or infirmity.
- **Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which is caused by an alteration of nervous system function and interference with 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 subluxation. However, if during the course of a chiropractic neurological examination, 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 another health care provider.

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 find and remove vertebral subluxations. Our only method is specific adjusting to correct neurological subluxations.

I hereby consent to and authorize the administration of all diagnostic and chiropractic treatments that may be considered advisable or necessary in the judgment of Power Chiropractic Health. **I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that while Power Chiropractic Health may prepare necessary reports and forms to assist me in making collections from the insurance company, all services rendered to me are charged directly to me and I am personally responsible for payment.**

I have read, understand, and agree to, the above statements.

Signature (Parent/guardian, when applicable): _____Date: _____

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his associates have my permission to perform an x-ray evaluation if necessary. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period _____ Signature_____ Date_____

If This Health Profile Is for A MINOR/CHILD, Please Fill Out and Sign Below

Name of Practice Member Who Is a Minor/Child: _____

I authorize Dr. Karl Baune, D.C. and any and all Power Chiropractic Health staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Power Chiropractic Health.

Guardian Signature: _____ Date: _____ Relationship to Minor/Child _____