

NAME _____ DATE _____

WEIGHT _____ HEIGHT _____ AGE _____

PRESENT COMPLAINT _____

WHEN DID THIS PROBLEM START? _____

DID YOU DO ANYTHING THAT BROUGHT THIS PROBLEM ON? _____

HOW DOES THE PROBLEM FOR WHICH YOU ARE SEEING THE DOCTOR TODAY
AFFECT YOUR WORK OR DAILY ACTIVITIES? _____

HAVE YOU EVER HAD THIS PROBLEM BEFORE? _____ WHEN? _____

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? _____ WHO? _____

ARE YOU TAKING ANY MEDICATIONS? _____ FOR WHAT CONDITION?

DO YOU SUFFER FROM ANY SERIOUS SYSTEMIC DISEASES? _____

WHAT OPERATIONS HAVE YOU HAD? _____

HAVE YOU HAD ANY BROKEN BONES? ____ NAME THEM _____

HAVE YOU HAD ANY BAD FALLS OR ACCIDENTS? _____

WHEN AND DESCRIBE _____

WOMEN ONLY:

I AM NOT KNOWINGLY PREGNANT AT THIS TIME. _____

SIGNED

DO NOT WRITE BELOW *DOCTOR' S USE ONLY*

CONFIDENTIAL CASE HISTORY

DATE _____

FULL NAME _____
(first) (middle) (last)

ADDRESS _____
(street) (city/state) (zip)

PHONE NO _____ AGE _____ BIRTHDATE _____

SEX _____ MARITAL STATUS M S W D NUMBER OF CHILDREN _____

SOCIAL SECURITY NO _____ LICENSE NO _____

OCCUPATION EMPLOYER _____

WORK ADDRESS _____ WORK PHONE _____

SPOUSE'S NAME _____ SPOUSE'S BIRTHDATE _____

SPOUSE'S OCCUPATION _____ EMPLOYER _____

WORK ADDRESS _____ WORK PHONE _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

HOW DID YOU BEAR ABOUT OUR OFFICE? _____ YELLOW PAGES _____ NEWSPAPER

_____ RADIO _____ SPINAL SCREENING _____ REFERRAL WHO? _____

INSURANCE INFORMATION :

PRIMARY INSURANCE CO _____

INSURED'S NAME _____ SOCIAL SECURITY NO _____

INSURED'S PLACE OF EMPLOYMENT _____

SECONDARY INSURANCE COMPANY _____

INSURED'S NAME _____ SOCIAL SECURITY NO _____

INSURED'S PLACE OF EMPLOYMENT _____

IF RELATED TO AN ACCIDENT, PLEASE ANSWER THE QUESTIONS BELOW:

WERE YOU INJURED ON THE JOB? _____

WERE YOU INVOLVED IN AN AUTOMOBILE ACCIDENT? _____

OTHER _____

SIGNED

I understand and agree that health and accident insurance policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that TINIUS CHIROPRACTIC CENTER will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to TINIUS CHIROPRACTIC CENTER will be credited to my account on receipt. However, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

TELL US WHERE YOU HURT

Name _____

Date _____

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols listed below.

Ache AAAA
AAAA

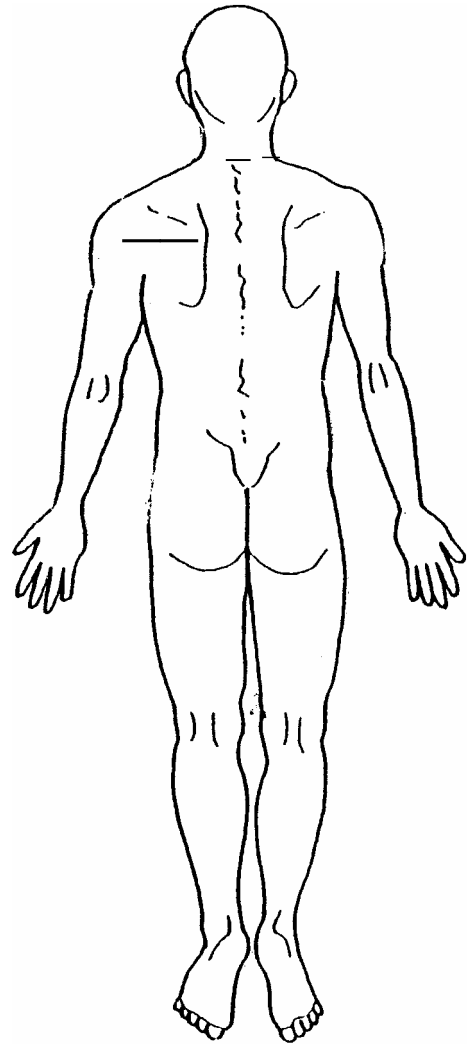
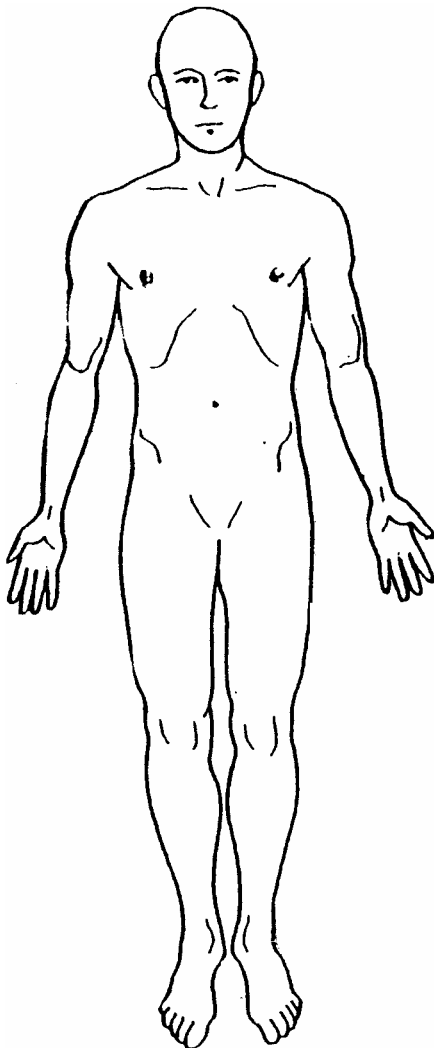
Numbness NNNN
NNNN

Pins and Needles PPPP
PPPP

Burning BBBB
BBBB

Stabbing SSSS
SSSS

Throbbing TTTT
TTTT



Please mark on the line to indicate how severe your pain has been.

NO PAIN _____

SEVERE PAIN

HIPAA Consent Form

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.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Tinius Chiropractic Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Tinius Chiropractic Center. I understand that diagnosis or treatment of me by Tinius Chiropractic Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Tinius Chiropractic Center is not required to agree to the restrictions that I may request. However, if Tinius Chiropractic Center agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Tinius Chiropractic Center has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Tinius Chiropractic Center's Notice of Privacy Practices prior to signing this document. The Tinius Chiropractic Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Tinius Chiropractic Center. The Notice of Privacy Practices for Tinius Chiropractic Center is also provided in the HIPPA handbook in the reception area and on the Tinius Chiropractic Center website at www.tiniuschiropractic.com This Notice of Privacy Practices also describes my rights and the Tinius Chiropractic Center's duties with respect to my protected health information.

Tinius Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Tinius Chiropractic Center's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

X

Signature of Patient or Personal Representative

X

Name of Patient or Personal Representative

HIPAA Authorization Form "A"

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.

I, _____, hereby authorize Tinius Chiropractic Center to use the following protected health information, and/or disclose the following protected health information to:

This protected health information is being used or disclosed to inform another physician, insurance company or its representatives, attorney, or other sources necessary for referral, treatment, reimbursement or other legal reasons.

This authorization shall be in force and effect until six (6) years from the date of this authorization at, which time this authorization to use or disclose this protected health information, expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Larry H. Tinius D.C. at Tinius Chiropractic Center. I understand that a revocation is not effective to the extent that Tinius Chiropractic Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may

be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Tinius Chiropractic Center will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.) I further understand that I may refuse to sign this authorization.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Tinius Chiropractic Center from a third party.

X _____

Signature of Patient or Personal Representative

_____ Date

_____ Name of Patient or Personal Representative

_____ Description of Personal Representative's Authority

Patient Acknowledgment of Privacy Notice

To Be Maintained with Patient's Chart

This is to acknowledge that I (print name) _____
have been given the opportunity to review Tinius Chiropractic Center's, **Notice of Privacy Practices**. I
understand that I have the right to request a personal copy of this office's **Notice of Privacy Practices**.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

INSURANCE QUESTIONNAIRE

NAME: _____ AGE : _____ SEX: _____

ADDRESS: _____

DATE OF ACCIDENT: _____

TYPE OF ACCIDENT: () AUTOMOBILE () INDUSTRIAL () FALL () OTHER

WHERE AND WHEN DID THE ACCIDENT TAKE PLACE? _____

AREA OF BODY INJURED? () NECK () UPPER BACK () MID-BACK () LOW BACK

HAVE YOU EVER INJURED THIS AREA BEFORE? () YES () NO

STATE IN YOUR OWN WORDS HOW ACCIDENT HAPPENED AND DESCRIBE INJURIES RECEIVED:

OCCUPATION: _____

EMPLOYED BY: _____

DID YOU NOTIFY YOUR EMPLOYER: _____

DOES YOUR PRESENT JOB AGGRAVATE YOUR CONDITION? () YES () NO

HAVE YOU MISSED WORK SINCE THE ACCIDENT? _____ DAYS _____ WEEKS _____ MONTHS

DATES OF TOTAL DISABILITY FROM _____ TO _____

DATES OF PARTIAL DISABILITY FROM _____ TO _____

HAVE YOU BEEN SEEN BY ANY OTHER DOCTOR FOR THIS INJURY? () YES () NO

NAME OF DOCTOR: _____

WHAT WAS HIS DIAGNOSIS? _____

WERE YOU HOSPITALIZED? () YES () NO

IF SO, NAME HOSPITAL _____ DATE OF : _____

SINCE THE ACCIDENT HAS YOUR CONDITION: () IMPROVED () STAYED SAME () WORSENERD

DATE _____ SIGNATURE _____

JOB DESCRIPTION

() CURRENT () PAST

NAME _____
 DATE OF INJURY EMPLOYER _____
 ADDRESS _____

Note: In terms of an 8 hour workday, "Occasionally" equals 33%, "Frequently" equals 34% to 66%, and "Continuously" equals 67% to 1000.

In an 8 hour workday I: (Circle full capacity for activity)

Sit - Number of hours: 1 2 3 4 5 6 7 8
 Stand - Number of hours: 1 2 3 4 5 6 7 8
 Walk - Number of hours: 1 2 3 4 5 6 7 8

On the job I:

	Not at all	Occasionally	Frequently	Continuously
Bend/ stoop	()	()	()	()
Squat	()	()	()	()
Crawl	()	()	()	()
Climb	()	()	()	()
Reach above shoulder level	()	()	()	()
Crouch	()	()	()	()
Kneel	()	()	()	()
Balancing	()	()	()	()
Pushing/Pulling	()	()	()	()

On the job I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 lbs.	()	()	()	()
11 to 24 lbs.	()	()	()	()
25 to 34 lbs.	()	()	()	()
35 to 50 lbs.	()	()	()	()
51 to 74 lbs.	()	()	()	()
75 to 100 lbs.	()	()	()	()

Must you bend over while doing any lifting? () Yes () No

On the job, are the feet used for repetitive movements as in operating foot controls?

Right: () Yes () No Left: () Yes () No
 Both: () Yes () No

Hand use for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right	() Yes () No	() Yes () No	() Yes () No
Left	() Yes () No	() Yes () No	() Yes () No

Signature: _____

Name _____

Does the job require:

A. Working on unprotected heights? () Yes () No

Comments _____

B. Being around moving machinery? () Yes () No

Comments _____

C. Exposure to marked changes in temperature and humidity? () Yes () No

Comments _____

D. Driving automotive equipment? () Yes () No

Comments _____

E. Exposure to dust, fumes, gases? ()Yes ()No

Comments _____

ADDITIONAL COMMENTS: _____

Signature: _____