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.

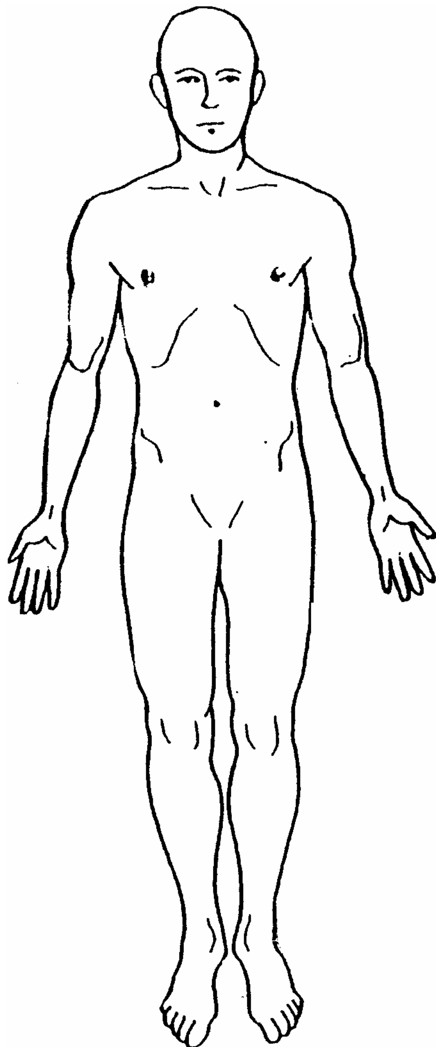
TELL US WHERE YOU HURT

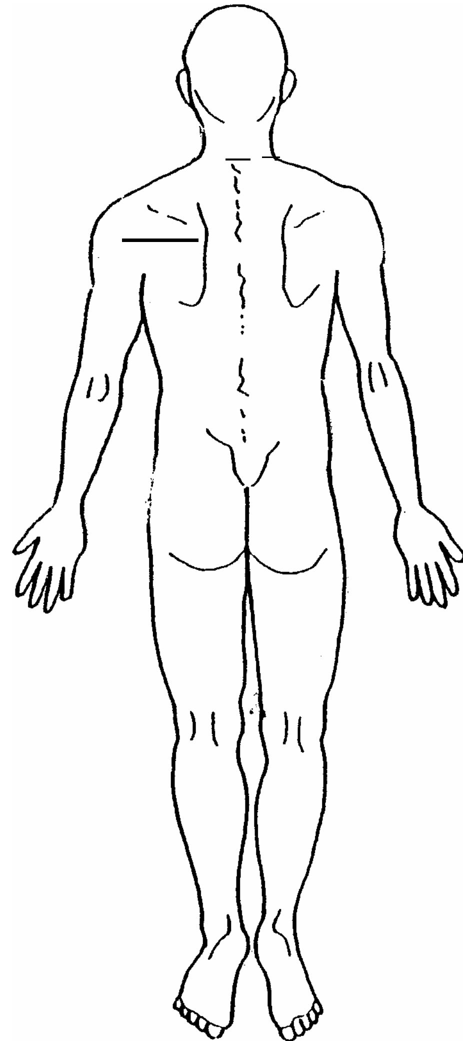
Name ___________________________________ Date________________________

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 INFORINIATION ABOUT YOU MAY BE USED ANTI) 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.**

____ ________________
Sianature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority