CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

Email: _____ Gender: ☐ M / ☐ F Marital Status: ☐ Married / ☐ Single / ☐ Other

Date of Birth: _____ Occupation: _____

Spouse/Significant Other: _____

Referred by *(name)*: _____

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: _____

-CMS requires providers to report both race and ethnicity-

Ethnicity: ☐ Not Hispanic or Latino / ☐ Hispanic or Latino / ☐ Other / ☐ Decline to Answer Preferred Language: _____

Race: ☐ Asian / ☐ Black or African American / ☐ American Indian or Alaskan Native / ☐ White (Caucasian) / ☐ Hawaiian or Pacific Islander / ☐ Other / ☐ Decline

Smoking Status: ☐ Every Day / ☐ Some Days / ☐ Former / ☐ Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ Preferred Contact Number: _____

Relationship: ☐ Child / ☐ Parent / ☐ Spouse / Other: _____

Primary Care Physician: _____ Doctor's Phone: _____

FINANCIAL INFORMATION -- ***Please allow us to photocopy your insurance card.***

☐ ☐ ☐ Other (please explain) _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

Policy Holder: _____ Policy Holder: _____

Relation to Insured: ☐ Self / ☐ Spouse / ☐ Parent / ☐ Child / ☐ Other

Relation to Insured: ☐ Self / ☐ Spouse / ☐ Parent / ☐ Child / ☐ Other

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS* Pediatric Patient Information:

Present Health Challenges:

For what health challenge(s) is your child here for?

_____

_____

When did it begin? _____

Has your child seen other health care practitioners for this? What did they recommend?

_____

_____

Is this dysfunction getting progressively worse? ☐ Yes ☐ No

Health History:

Symptoms: Please check any current or past problems on the list below:

☐ ADHD	☐ Constipation	☐ Asthma
☐ Autism	☐ Bed Wetting	☐ Chronic Earaches
☐ Colic	☐ Digestive Problems	☐ Frequent colds
☐ Muscle Pain	☐ Neck Pain	☐ Nightmares
☐ Reflux/Spitting Up	☐ Gassy	☐ Difficulty Latching
☐ Bloating	☐ Trouble Sleeping	☐ Other: _____

Prenatal History:

Location of Birth: ☐ Home ☐ Birth Center ☐ Hospital

Complications during pregnancy: ☐ ☐ Yes/No List: _____

Medication during pregnancy/delivery: _____

Birth Intervention: ☐ Forceps ☐ Vacuum ☐ Caesarian

Complications during delivery: _____

Feeding History:

If currently breast feeding does baby latch easily on both sides? ☐ Yes ☐ No

Breast or formula fed? _____ How long? _____

Signature of parent/guardian _____ **Date** _____

Does anyone in your IMMEDIATE family have a history of (circle condition): ☐NONE

Heart Disease If yes, who _____ **Stroke** If yes, who _____

Cancer If yes, who _____ Type_____

Other Relevant Family History: _____

PAST HEALTH HISTORY: (List even if it was 20 years ago…)

Injuries, Traumas or Hospitalizations: ☐NONE _____

Surgeries – Date, Type and Reason: ☐NONE _____

Breastfeeding Symptoms, Do you or your baby *CURRENTLY* experience any of these symptoms? (Check all that apply)

Baby symptoms:

- ☐ N/A
- ☐ Poor latch with breast or bottle
- ☐ Reflux Symptoms
- ☐ Spits up with most feeds
- ☐ Frequent hiccups
- ☐ Gassy
- ☐ Colic
- ☐ Clicking or smacking sounds with feeding
- ☐ Cries a lot/extra fussy
- ☐ Falls Asleep when feeding
- ☐ Poor weight gain
- ☐ Milk dribbles out of the corners of the mouth when feeding
- ☐ Choking, gulping, gasping at the breast
- ☐ Difficulty maintaining latch
- ☐ Congested nose
- ☐ "Noisy" baby when sleeping, snoring, loud breathing
- ☐ Mouth breathing/mouth opened when sleeping
- ☐ Frustrated when at the breast
- ☐ White coating of tongue
- ☐ Gagging when feeding
- ☐ Slides on and off the nipple when breastfeeding
- ☐ Biting and chewing the nipple
- ☐ Pacifier falls out
- ☐ Cranial asymmetries
- ☐ Preferred Head position when feeding

Mothers Symptoms when breastfeeding:

- ☐ N/A
- ☐ Painful Nursing (only 50% of ties will have maternal pain)
- ☐ Lipstick shaped nipple
- ☐ Cracked, creased, flattened nipple
- ☐ Bleeding and damaged nipples
- ☐ Incomplete emptying of the breast
- ☐ Low Supply
- ☐ Clogged ducts, engorgement, mastitis
- ☐ Prolonged feedings/feeding feels like a full time job
- ☐ Baby gets tired and fatigued

Is there anything else you would like the doctor to know? _____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature _____ Date_____

Doctor Signature _____ Date _____

Todd Harrison, D.C.
1118 12th Ave S, Nampa, ID 83651
Revised 08.29.2015

Patient Name: _____ D.O.B.: _____ Date: _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUHORIZATIONS: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: by signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arrangement between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to be paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignments below." Box 13 reads as follow: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPPA), updated September 23, 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitation of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATEMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By singing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of your knowledge.

Signature of Patient: _____

Signature of Parent or Guardian: _____

Informed Consent for Chiropractic Treatment

Todd Harrison, DC
1118 12th Avenue South, Nampa, ID 83651
Phone: 208-965-8784

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to:

- Broken bones
- Dislocations
- Sprains/strains
- increased symptoms and pain
- No improvement of symptoms or pain
- Worsening/aggravation of spinal conditions
- Other _____

In rare cases there have been reported complications of arterial dissections (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____ _____
witness to patient's signature date

_____ _____
translated by date

Revised 09-28-2017