CATALYST HEALTH CENTER

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Comprehensive Health History Forms

Patient Information

Patient Name:_____ **DOB**:_____ **Gender**: ○M or ○F

Address: _____ **City**:_____ **State**:_____ **Zip Code**:_____

Phone Number:_____ **Email**:_____ **Best to Reach**: ○Phone ○Email

Occupation:_____ **Employer**:_____ **Phone**:_____

Marital Status: ○Single ○Married ○Widowed ○Divorced ○Separated **Spouse's Name**:_____

Spouse's Occupation:_____ **Spouse's Employer**:_____

Emergency Contact: _____ **Relationship**: _____ **Phone**:_____

How Did You Hear About Us? ○Internet ○Event_____ ○Referral_____

What specific condition brought you into the office? _____

Previous Care

What type of treatment have you received for this condition?_____

Did it resolve the condition? ○Yes ○No

Primary Care Physician's Name:_____

Clinic Name:_____

Clinic Phone Number:_____

I allow my health progression to be shared with my primary care physician: ○Yes ○No

Lifestyle History

Check Your Exercise Level: ○Inactive ○Light Activity ○Moderate Activity ○Heavy Activity ○Vigorous Activity

Please check all that apply:
□Tobacco □Alcohol □Coffee/Caffeine Beverages
Do you currently or have previously used recreational drugs?
○Yes ○No If yes, what types/method used (IV, inhaled, etc)_____

Daily Activities

Effects of Current Condition on Daily Performance
Please check all that apply

□Bending Neck Forward	□Rolling Over
□Bending Neck Back	□Extending Arms Up
□Turning Neck Rt to Lt	□Pushing
□Turning Neck Lt to Rt	□Pulling
□Twisting At the Waist	□Shoveling
□Bending Side to Side	□Lifting > 10 lbs.
□Bending Backward	□Running
□Bending Forward	□Walking
□Standing Erect	□Climbing Uphill
□Standing to Sitting	□Climbing Stairs
□Sitting to Standing	□Climbing Ladders
□Sitting Over 60 min.	□Walking Downhill
□Standing Over 60 min.	□Getting Dressed
□Sitting to Lying Down	□Sexual Activity
□Lying Down > 60 min.	□Sleeping
□Lying Down to Sitting	□Watching TV

Work Activity

Work Activity Level:
○Full-time ○Part-Time ○Homemaker ○Student ○Unemployed

Labor Activity:
○ Light ○ Moderate ○ Heavy ○ Sedentary

Work Activity Postures: (Select all that apply)

□ Bending	□ Climbing	□ Kneeling	□ Pulling
□ Pushing	□ Reaching	□ Sitting	□ Standing
□ Twisting	□ Walking	□ Computer	□ Repetitive

Medical History

Surgeries (Select all that apply)
□None □Appendectomy □Cardiac Bypass □C-Section
□Gall Bladder □Implants □Tonsillectomy □Carpal Tunnel
□Cataracts □Hysterectomy □Knee □Wisdom Teeth
□Spinal_____
□Other_____

Injuries (Select all that apply)
□Back Injury □Head Injury □Neck Injury □Soft Tissue
□Broken Bones/Fractures □Severe Fall

Family History (Select all that apply)
□Cancer □Diabetes □Asthma □Autoimmune (Lupus) □Hypertension
□Heart Disease □Parkinson's □Stroke □Rheumatoid Arthritis

Current Condition(s)

Please identify the condition (s) that brought you into the office in order of importance and please mark "C" for constant pain or "I" for intermittent pain:

1. _____ ○C or ○I
2. _____ ○C or ○I
3. _____ ○C or ○I
4. _____ ○C or ○I

Rate your pain for each of your complaints on a scale of 0 to 10 with 10 being the worst pain and 0 being no pain:

Primary complaint ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Second complaint ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Third complaint ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Fourth complaint ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

When did the condition begin? _____

Has it occurred before? ○ Yes ○ No

Is the condition getting worse? ○ Yes ○ No ○ Unknown

What relieves your symptoms? _____

What makes your symptoms worse?_____

Do your symptoms cause you to feel worse in the:
□ AM □ PM □ Mid-day □ Late PM

Is the Condition: □ Auto Related □ Job Related □ Home Injury
□ Slip/Fall □ Lifting □ Slept Wrong □ Unknown Cause
□ Other _____

Does it interfere with:
□ Work □ Sleep □ Daily Routine □ Recreation

What treatment have you received for your condition?
□ Medication □ Surgery □ Physical Therapy
□ Chiropractic Services □ None □ Other_____

How long ago did you receive treatment?_____

Please list medications taken to treat these conditions and list how often you take them:_____
_____

What were the results? ○ Favorable ○ Unfavorable
If unfavorable, please explain:_____

Current Medications

Please list medications and supplements:

_____

_____

Food and Medication Allergies: _____

Do you have any surgical devices in your body? (*ie screws, pins, plates, etc)* ○ No ○ Yes If yes, where located _____

Have you had prolonged or regular use of any of the following:
□NSAIDS (Advil, Aleve, Motrin or Aspirin) □Tyenol □Steroids

Review of Symptoms and Past Medical History

Please mark "C" for current symptoms, "P" for past symptoms or leave blank if never.

Ears/Nose
Ear Pain/Ear Infection ○C ○P
Hay fever ○C ○P
Ringing in Ears ○C ○P
TMJ ○C ○P

Eyes/Vision
Blindness ○C ○P
Blurred/Double Vision ○C ○P
Cataracts ○C ○P
Glaucoma ○C ○P

Skin
Eczema ○C ○P
Hives ○C ○P
Rashes ○C ○P

Cardiovascular
Chest Pain ○C ○P
Congestive Heart Failure ○C ○P
Coronary Artery Disease ○C ○P
Heart Murmur ○C ○P
Pacemaker/Defibrillator ○C ○P
Palpitations ○C ○P
Swelling of Legs ○C ○P

Hematologic
Anemia ○C ○P
Easy Bleeding/Bruising ○C ○P
Blood Clotting ○C ○P

Musculoskeletal
Ankle/Foot Pain ○C ○P
Arthritis ○C ○P
Balance Problems ○C ○P
Elbow Pain ○C ○P
Fibromyalgia ○C ○P
Hip Pain ○C ○P
Joint Pain ○C ○P
Knee Pain ○C ○P
Low Back Pain ○C ○P
Muscle Aches ○C ○P
Muscle Cramping ○C ○P
Muscle Stiffness(in a.m.) ○C ○P
Neck Pain ○C ○P
Pain Between Shoulder ○C ○P
Pain Wakens You ○C ○P
Shoulder Pain ○C ○P
Weakness in Arms/Legs ○C ○P
Wrist/Hand Pain ○C ○P

Gastrointestinal
Abnormal Stool ○C ○P
Constipation ○C ○P
Crohn's Disease ○C ○P
Diarrhea ○C ○P
Reflux/Heartburn ○C ○P
Nausea/Vomiting ○C ○P

Throat/Respiratory
Asthma/ Wheezing ○C ○P
Chronic Cough ○C ○P
Chest Congestion ○C ○P
Difficulty Swallowing ○C ○P
Hoarseness ○C ○P
Shortness of Breath ○C ○P
Sore Throat ○C ○P

Endocrine
Diabetes ○C ○P
Fatigue/Drowsiness ○C ○P
Goiter ○C ○P
Hypo/Hyper Thyroid ○C ○P
Weight Loss/Gain ○C ○P

Neurological
Dizziness ○C ○P
Facial/Limb Weakness ○C ○P
Fainting ○C ○P
Headaches ○C ○P
Migraines ○C ○P
Numbness/Tingling ○C ○P
Seizures ○C ○P
Sleep Disturbance ○C ○P
Slurred Speech ○C ○P
Stroke ○C ○P
Tremor ○C ○P

Mental/Emotional
Anxiety/Panic ○C ○P
Clumsy ○C ○P
Confusion ○C ○P
Convulsions ○C ○P
Depression ○C ○P
Foggy Thinking ○C ○P
Forgetfulness ○C ○P
Hyperactive ○C ○P
Insomnia ○C ○P
Memory Loss ○C ○P
Mood Swings/Irritability ○C ○P
Poor Concentration ○C ○P
Restless Leg Syndrome ○C ○P

Urinary
Blood in Urine ○C ○P
Burning or Pain ○C ○P
Kidney Stones ○C ○P
Urgency ○C ○P

Reproductive
Males Only:
Erectile Dysfunction ○C ○P
Impotence ○C ○P
Prostate Enlargement ○C ○P

Females Only:
Cramps ○C ○P
Decreased Libido ○C ○P
Infertility ○C ○P
Heavy Bleeding ○C ○P
Irregular Menstruation ○C ○P
Ovarian Cysts ○C ○P
Painful Periods ○C ○P

Terms of Acceptance/Patient Health Information Consent Form

When a person seeks Chiropractic care and we accept a person 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 person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the 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 infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction and lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease other than vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek other healthcare providers.

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 locate, analyze and correct vertebral subluxation by specific adjustments.

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 healthcare operation, we 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 HPI, we encourage you to read the HIPAA notices that are 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 PHI for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the health insurance company 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 with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given in the office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request but would apply to any care given after the request has been processed.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. 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 healthcare operations, the chiropractic physician has the right to refuse to give care.

Authorization for Release of Medical Records: I request that payment of authorized Insurance/Medicare/Medicaid benefits be made directly to Catalyst Health Center for any services provided to me by this facility. I hereby authorize the release of all medical information about me to the Health Care Finance Administration or other insurer or agency for purposes of determining medical necessity or processing claims at Catalyst Health Center. This authorization is in effect until I choose to revoke it. I have the right as a patient to revoke this authorization in writing at any time.

Signature:_____ **Date:**_____

Pregnancy Release- Females Only

This is to certify that to the best of my knowledge, I am not pregnant and the doctors and staff of Catalyst Health Center have my permission to perform x-ray(s). I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period:_____ **Signature:**_____ **Date:**_____

Consent to Evaluate and Adjust a Minor Child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature:_____ **Date:**_____

Notice of Privacy Practices Acknowledgement (HIPAA)

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Signature:_____ **Date:**_____

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. By signing this agreement, you understand that you are responsible for all charges during your treatment regardless of any insurance coverage. We will file your insurance if available but it is not a guarantee of payment. You are ultimately responsible for your entire bill. From time to time, your insurance company may require information from you. Please return all forms back to them as soon as possible. Delaying this will cause your claims to be denied. If needed information is not returned, you could be totally responsible for your bill. We will do all we can to help get your claims paid but often your help is required too. Please keep in mind that sometimes it takes weeks or months to process delays in and out of our office. We do accept cash, checks, debit and credit cards for your convenience. We ask that all co-pays be paid at the time of your visit. Deductible and co-insurance amounts will be discussed at that time of your visit.

"I have read, understand and agree to all provisions of this policy."

Signature:_____ **Date:**_____

Media Consent

I,_____, give Catalyst Health Center unrestricted permission to use my image in print, video, digital and social media. I agree that these images may be used by Catalyst Health Center for a variety of purposes and that these images may be used without further notification.
By signing below, I am agreeing that there will be no financial or other compensation for using my image. I also consent that my name and identity may be revealed in the descriptive text or commentary.
By granting Catalyst Health Center permission to use my image, I am confirming that I am at least 18 years of age and have read and understand the previous statements and am competent to execute this agreement.

Signature:_____ **Date:**_____

Assignment and Release I understand and agree that (regardless of whatever health or medical benefits I have), I am ultimately responsible to pay CATALSYT HEALTH CENTER, PA, the balance due on my account for any professional services rendered and for any supplies, tests or medications provided. I hereby authorize payment of any health insurance or medical plan benefits directly to CATALYST HEALTH CENTER, PA, for medical services rendered and for any supplies, tests or medications provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to CATALYST HEALTH CENTER, PA, all rights to payments and benefits and all legal and other health plan that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This assignment includes, but not limited to, a designation that CATALYST HEALTH CENTER, PA, can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to CATALYST HEALTH CENTER, PA, as a result of services rendered by CATALYST HEALTH CENTER, PA, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

_____	_____	_____
Signature of Patient, Parent or Guardian	Relationship to Patient	Date