Confidential Patient Data

Name:	**Middle Int.**	**Today's Date:**
Mailing Address:		
City:	**State:**	**Zip:**
❑Male ❑Female	**Height**	**Weight**
Marital Status: ❑Married ❑Single ❑Widowed ❑Divorced	**Spouses Name;**	
Date of Birth	**Who can we thank for referral?**	
Home Ph:	**Work Ph:**	**Cell Ph:**
Email:		
Name(s) and Age(s) of Children:		
Recent Work-Related Injury? ❑Yes ❑No	**Recent Auto Accident? ❑Yes ❑No**	
Previous Chiropractic Care? :❑No ❑Yes	**Approximate Last Visit Date**	

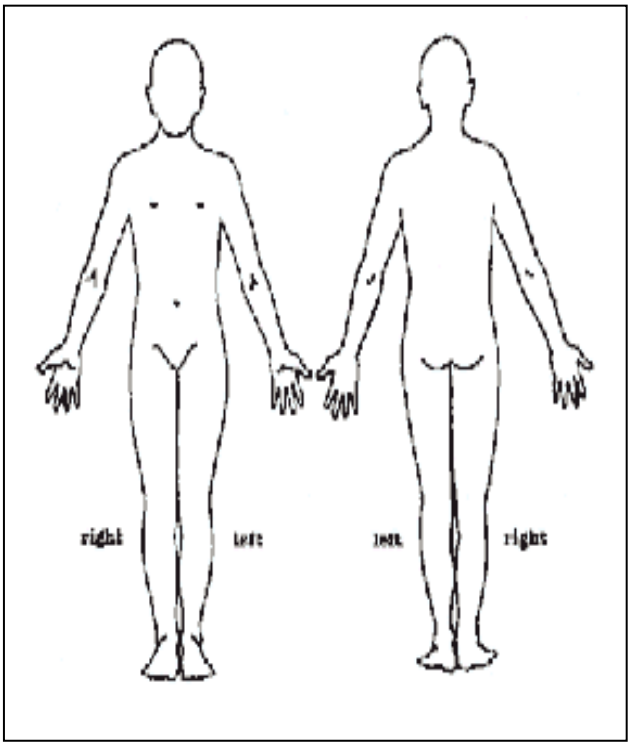
RATE YOUR PAIN BY CYRCLING; 10 BEING THE WORST

1ST CONDITION 10 9 8 7 6 5 4 3 2 1

2ND CONDITION 10 9 8 7 6 5 4 3 2 1

3RD CONDITION 10 9 8 7 6 5 4 3 2 1

Mark your pain location with an X



What causes your pain?

	BENDING		**COUGHING**		**LIFTING**
	REACHING		**SITTING**		**SNEEZING**
	STRAINING AT STOOL		**TURNING HEAD**		**WALKING**
	LYING DOWN		**STANDING**		**SLEEPING**

Describe the quality of pain;

CONDITION		**CONDITION**	
	Dull		Numb
	Throbbing		Tingling
	Stabbing		Sharp
	Crushing		Burning

SYMPTOMS HAVE PERSISTED FOR
____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

Pain worse in ❑Morning ❑Afternoon ❑Night ❑Never changes

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN?_____

√ Check *the following conditions that **YOU** have had .**X** conditions that are common to FAMILY MEMBERS*

	AIDS		**Concussion**		**HIV/ARC**		**Poor circulation**
	Anemia		**Convulsions**		**Kidney disorder**		**Hepatitis**
	Alcoholism		**Diabetes**		**Bowel control loss**		**Rheumatic fever**
	Arthritis		**Indigestion**		**Menstrual cramps**		**Rheumatism**
	Asthma		**Dislocated joints**		**Multiple sclerosis**		**Scarlet fever**
	Back pain		**Epilepsy**		**Muscular dystrophy**		**Serious injury**
	Bladder trouble		**German Measles**		**Neck pain**		**Sinus trouble**
	Bone fracture		**Headaches**		**Nervousness**		**Tuberculosis**
	Cancer		**Reproductive disorder**		**Numbness**		**Venereal disease**
	Chest pain		**High blood pressure**		**Polio**		**Other**

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____ Date of Last Physical Exam_____

SURGICAL HISTORY:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

Have you ever had a metal implant? ❑Yes ❑No

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. _____Date:_____
❑Job ❑Auto ❑Other 2._____Date:_____
❑Job ❑Auto ❑Other 3._____Date:_____

If you take prescription medications, please let us know the conditions for which you take the medication and what the medications are: _____
_____
_____

ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD_____

What is your occupation _____

PLEASE **√** ***CHECK*** *ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:*

	Blurred vision		**Concentration loss/confusion**		**Light bothers eyes**
	Buzzing in ears		**Constipation or upset stomach**		**Loss of balance**
	Cold feet		**Depression**		**Loss of smell**
	Cold sweats		**Insomnia**		**Loss of taste**
	Low resistance to colds		**Numbness in toes**		**Ringing in ears**
	Muscle jerking		**Pins and needles in arms**		**Shortness of breath**
	Numbness in fingers		**Pins and needles in legs**		**Stiff neck**

I hereby authorize and release Dr. Oberle to administer treatment, physical examination, motion/posture exam, laboratory procedures, chiropractic care or any clinical services that he/she deems necessary in my case.

Patient Signature:_____
Date:_____

HIPAA Notice of Privacy Practices

Live Life Stay Young Chiropractic

THIS NOTICE DESCRIBES HOW HEALTH CARE 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 how we 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 rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, 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 protected health information may be used and disclosed by your physician, our 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 the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to health care students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include ; as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors, and Organ Donation. Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary 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.

Patient Signature_____ Date Signed_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and I, Dr Oberle, accept a patient for such care, it is essential for both of us 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 corrections of spinal nerve interference. 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: Also known as spinal nerve interference. A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential. I, Dr Oberle, do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic unusual findings, I 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 method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
All questions regarding to doctor's objective pertaining to my care in this office have
been answered to my complete satisfactions. I therefore accept chiropractic care on this basis.

_____ _____
(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 are.

Pregnancy Release
This is to certify that to the best of my knowledge I may not pregnant and the above
doctor and his/her associates have my permission to perform an x-ray evaluation. I have been
advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:_____

_____ _____
(Signature) (Date)