FREITAG
FAMILY CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

Freitag Family Chiropractic LLC is committed to patient privacy and the confidentiality of personal health information entrusted to us.

The ways in which we may use or disclose your health information are detailed in the Notice of Privacy Practices, a copy of which is located on our New Patient Forms Page on our website: www.freitagfamilychiropractic.com. You may also request a copy of this document from our office.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

Your Right to Request that Your Patient Record be Amended: You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record we will provide you with a Request to Amend Protected Health Information form.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, FREITAG FAMILY CHIROPRACTIC LLC WILL NOT BE ABLE TO DISCLOSE IMPORTANT INFORMATION TO OUTSIDE HEALTH CARE PROVIDERS IN THE EVENT OF AN EMERGENCY OR COORDINATION OF CARE.

Initial here [ ] I acknowledge review of the Freitag Family Chiropractic - Notice of Privacy Practices.

By signing below, I give consent to Freitag Family Chiropractic clinicians or staff to use or disclose my personal health information as noted in the Notice of Privacy Practices.

Patient Printed Name _____ Date ____ / _____ /_____

Patient Signature _____

Guardian Name & Relationship _____ Date ____ / _____ / _____

Guardian Signature_____

FREITAG FAMILY CHIROPRACTIC

Legal Name _____

Preferred Name _____

Address _____

_____

City _____ State _____ Zip _____

Cell # _____

Home # _____

Email Address _____

Emergency Contact _____

Relationship to you _____

Phone # _____

Today's visit related to:
☐ Auto ☐ Work ☐ Fall ☐ Sport Injury ☐ Other

How did you hear about our office?
☐ Google ☐ Social Media ☐ Referral: ☐ Other:

Referral/Other_____

Birth Date ___/____/____ Appt. Date___/____/____

☐ Male ☐ Female Height _____

Weight_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer _____

Type of work _____

Work # _____

Have you been treated by a chiropractor before?

☐ No ☐ Yes, Approx. date of last visit _____

How would you rate your overall health right now?
☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

PRIMARY COMPLAINT/CONCERN: _____
(If more than one area of concern, list following concerns on the next page)

When did this begin? _____

What caused this? _____

Since onset this has: ☐ Stayed the same ☐ Gotten worse
☐ Gotten better ☐ Comes and goes

What makes this better?

_____

What makes this worse?

_____

Has this occurred before? ☐ No ☐ Yes; explain:

_____

Have you had any past treatment for this concern?
☐ No. ☐ Yes, treatment: _____

Results: _____

Average Pain Intensity on a Scale of 0-10:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Does this discomfort travel/radiate anywhere?
☐ No. ☐ Yes; where? _____

Has this happened before? ☐ No. ☐ Yes; when _____

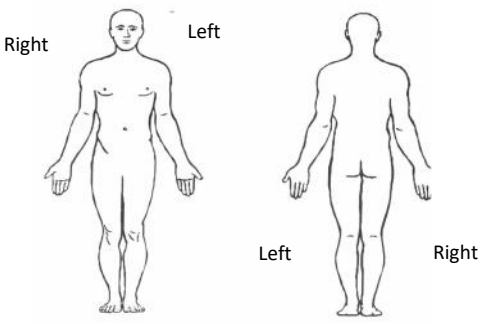
Describe this discomfort:
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Burning
☐ Sharp ☐ Throbbing ☐ Stabbing Needles ☐ Dull ☐ Achy
☐ Pins and Needles ☐ Tension ☐ Other Describe_____

How often does this discomfort occur?
☐ Constant (76-100% of the time) ☐ Frequent (51-75%)
☐ Occasional (26-50%). ☐ Intermittent (0-25%)

Does this interfere with:
☐ Daily routine ☐ Work/school ☐ Sleep ☐ Other activities
Please explain: _____

How do these symptoms impact your daily activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Please mark areas of concern on diagram



SECONDARY COMPLAINT/CONCERN: _____

_____

When did this begin? _____

What caused this? _____

Since onset this has: ☐ Stayed the same ☐ Gotten worse
☐ Gotten better ☐ Comes and goes

What makes this better?

_____

What makes this worse?

_____

Has this occurred before? ☐ No ☐ Yes; explain:

_____

Have you had any past treatment for this concern?
☐ No. ☐ Yes, treatment: _____

Results: _____

Average Pain Intensity on a Scale of 0-10:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Does this discomfort travel/radiate anywhere?
☐ No. ☐ Yes; where? _____

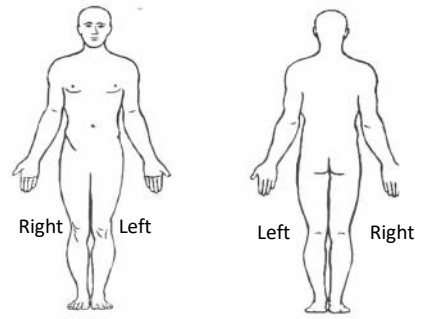
FREITAG FAMILY CHIROPRACTIC

Describe this discomfort (mark all that apply):
☐ Pain ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Burning
☐ Sharp ☐ Throbbing ☐ Stabbing Needles ☐ Dull ☐ Achy
☐ Pins and Needles ☐ Tension ☐ Other Describe_____

How often does this discomfort occur?
☐ Constant (76-100% of the time) ☐ Frequent (51-75%)
☐ Occasional (26-50%). ☐ Intermittent (0-25%)

Does this interfere with:
☐ Daily routine ☐ Work/school ☐ Sleep ☐ Other activities
Please explain: _____

How do these symptoms impact your daily activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely



Please mark areas of concern on diagram

GENERAL HEALTH HISTORY

Please indicate if you have had or currently have any of the following

Past	Present	
☐	☐	Severe/frequent headaches
☐	☐	Dizziness
☐	☐	Loss of vision/blurred vision
☐	☐	Hearing loss
☐	☐	Chronic ear infections
☐	☐	Ringing in the ears
☐	☐	Sinus problems
☐	☐	Dental or Jaw Problems
☐	☐	Frequent neck pain
☐	☐	Pain between shoulders
☐	☐	Heart attack
☐	☐	Congenital heart defect
☐	☐	Heart murmur
☐	☐	High/low blood pressure
☐	☐	Heart surgery/pacemaker
☐	☐	Shortness of breath
☐	☐	Asthma
☐	☐	Shingles
☐	☐	Numbness in arms/legs
☐	☐	Low back pain
☐	☐	Scoliosis
☐	☐	Herniated/Bulging Disc

Past	Present	
☐	☐	Thyroid problems
☐	☐	Diabetes Type I ____ II ____
☐	☐	Hepatitis Type _____
☐	☐	Digestive problems
☐	☐	Ulcers/colitis
☐	☐	Chronic Constipation
☐	☐	Chronic Diarrhea
☐	☐	Poor Appetite
☐	☐	Enlarged Prostate
☐	☐	Erectile Dysfunction
☐	☐	Irregular or painful menses
☐	☐	Kidney problems/stones
☐	☐	Frequent urination
☐	☐	Rheumatic fever
☐	☐	Alcohol/drug abuse
☐	☐	HIV/AIDS
☐	☐	Recent weight loss/gain
☐	☐	Anemia
☐	☐	Cancer/Type _____
☐	☐	Chemotherapy
☐	☐	Arthritis
☐	☐	Joint Replacement_____

Past	Present	
☐	☐	Fainting
☐	☐	Anxiety
☐	☐	Depression
☐	☐	ADD/ADHD
☐	☐	Stress
☐	☐	Multiple Sclerosis
☐	☐	Parkinson's Disease
☐	☐	Osteoporosis/osteopenia
☐	☐	Heartburn
☐	☐	Stroke history
☐	☐	Trouble sleeping
☐	☐	Frequent colds
☐	☐	Fibromyalgia
☐	☐	Other _____

Tobacco Use
☐ Never smoked ☐ Former smoker
☐ Current use, packs/day _____

Are you pregnant? ☐ Yes ☐ No
If yes, when is your due date _____
Are you nursing? ☐ Yes ☐ No

GENERAL HEALTH HISTORY (cont.)

FREITAG FAMILY CHIROPRACTIC

Average exercise level:

☐ None ☐ Light ☐ Moderate ☐Intense

Frequency of exercise:

☐ Daily ☐ Few times a week ☐Occasionally ☐ Other _____

Level of activity at work:

☐ Sedentary ☐ Active ☐ Physically demanding

Caffeine Use:

☐ None ☐ Occasional ☐ 1 drink/day ☐ 2 drinks/day ☐ 3+ drinks/day

Do you currently take any medications or vitamins?

☐ No ☐ Yes; please list _____

_____

Do you have any known allergies?

☐ No ☐ Yes; please list _____

_____

Please list any past accidents/injuries (work, auto, sports related, etc.):

_____

_____

Please list any previous surgeries/hospitalizations:

_____

_____

FAMILY HEALTH HISTORY

Please check each of the health conditions that a family member has now or has had in the past

Mother……☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Neurological Disorder ☐ Depression ☐ Arthritis
Maternal Grandmom……☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Neurological Disorder ☐ Depression ☐ Arthritis
Maternal Granddad……☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Neurological Disorder ☐ Depression ☐ Arthritis
Father:……☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Neurological Disorder ☐ Depression ☐ Arthritis
Paternal Grandmom……☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Neurological Disorder ☐ Depression ☐ Arthritis
Paternal Granddad……☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Neurological Disorder ☐ Depression ☐ Arthritis
Siblings……☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Neurological Disorder ☐ Depression ☐ Arthritis
Children……☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Neurological Disorder ☐ Depression ☐ Arthritis
Other……☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Neurological Disorder ☐ Depression ☐ Arthritis

Please specify any other significant family health conditions: _____

_____

PATIENT AUTHORIZATION

The statements made on this form are accurate to the best of my knowledge, and I agree to allow Freitag Family Chiropractic LLC to examine me for further evaluation. If I decide to receive care here, I hereby authorize the Dr. Freitag to work with my condition using adjustments/soft tissue work/additional modalities as he deems appropriate. I clearly understand and agree that all services rendered to me are my financial responsibility. I understand that Freitag Family Chiropractic LLC does not participate with Insurance and is not a Medicare provider therefore I am responsible for the full payment of my services as received. I understand that any health and accident insurance policies are an arrangement between myself and my insurance provider. If requested, documentation will be provided to me in order to submit the claims directly to my insurance company for reimbursement. In the event that an account become delinquent and a collection agency and/or law office is needed to collect on the account, the patient is responsible for all collection costs and/or attorney fees.

Patient (or Guardian) **Signature:** _____ **Date:** _____