ARNDT
CHIROPRACTIC CENTER
3359 Middle Road Suite 1 | Bettendorf, IA 52722
P 563.332.2211 | F 563.332.2210

PATIENT INFORMATION

How did you learn about us: _____

PATIENT

Last Name _____ First Name _____ Middle _____

Gender: M / F Date of Birth _____ Age _____ SS# _____ Race/Ethnicity _____

Preferred Language _____ Advance Directives: Living Will / Durable Power of Attorney / Do Not Resuscitate / None

Home Address _____ Apt # _____

City _____ State ____ Zip _____ Home # _____ Cell # _____

Employer Name _____ Occupation _____

Employer Address _____ City _____ State ____ Zip _____

Work # _____ E-mail Address _____

SPOUSE/SIGNIFICANT OTHER or GUARDIAN

Last Name _____ First Name _____ Middle _____

Employer Name _____ Contact # _____
Gender: M F Date of Birth _____ Age _____ SS# _____ Relationship _____

□ I authorize Arndt Chiropractic Center, Inc., its physicians and staff to discuss any medical information with this individual. I understand that I must contact Arndt Chiropractic Center, Inc. in writing in order to revise or terminate this consent.

EMERGENCY Name and address of nearest relative or friend not living with you.

Last Name _____ First Name _____ M.I. ____ Relationship _____

Home Address _____ Apt # _____

City _____ State ____ Zip _____ Contact # _____

□ I authorize Arndt Chiropractic Center, Inc., its physicians and staff to discuss any medical information with this individual. I understand that I must contact Arndt Chiropractic Center, Inc. in writing in order to revise or terminate this consent.

MY CERTIFICATION AND MY PRIVACY

I certify that the above information is correct and I request services.

I have received a copy of the **Notice of Privacy Practices.** I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

X _____ _____
Signature of patient or person acting on patient's behalf Date

Name: _____ **DOB/Age:** _____

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CHIEF COMPLAINT

Age:_____ **Sex:** □ F □ M **Dominate Hand**: □ R □ L **Who referred you to this office?**___ _____

Primary Care Doctor/location:_____ **Did they evaluate this problem**? □ Y □ N

What problem are you being seen for today? _____

_____

When did the problem start or what was the date of injury? _____

What was the cause of this injury? _____

What tests/treatments have you had for this problem? □ X-Rays □ MRI □CT Scan □Bone Scan □Ultrasound □ Surgery □Nerve Test (EMG/NCV) □Physical Therapy □Medications □Other:_____ **Where?**_____ **When?**_____

Since my problem has started, it is: □ Getting better □ Getting worse □ Unchanged

Has your problem kept you from: □ Working □ Recreational Activities □ Activities of daily living (cleaning & dressing)

I experience: □ Pain □ Numbness □ Tingling □ Weakness □ Swelling □ Stiffness □ Bruising □ Locking □ Catching □ Instability □ Loss of bowel/bladder control

□ Other: _____

The pain is: □ Constant □ Comes & goes (intermittent)

PAIN SCALE

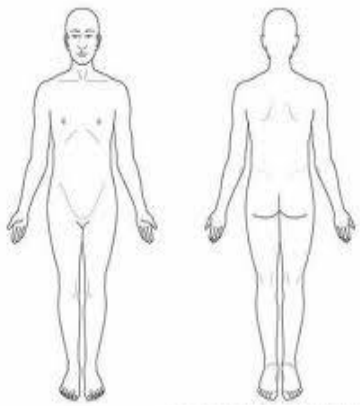
Circle the number that best reflects your pain.

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Place an 'X' on the drawing below on areas causing you pain and a letter describing it.

A = Ache
B = Burning
D = Dull
N = Numbness
S = Stabbing
T = Tingling



Does the pain radiate/travel/move? □ Y □ N

If yes, where?_____

Does your pain wake you from sleep? □ Y □ N

What makes your symptoms <u>worse</u>? □ Walking □ Stairs □ Exercising □ Twisting □ Kneeling □ Sitting □ Standing □ Direct pressure □ Lying flat □ Bending □ Lifting □ Coughing/sneezing □ Bowel movement □ Pushing □ Pulling □ In/out Car □ In/Out bed □ In/out Chair □ Looking over shoulder to drive □ Turning in bed □ Dressing □ Shoes on/off □Work activities □ Computer □ Sleeping □ Showering □ Washing/styling hair □Looking side/side □ Looking up/down □ Other:_____

What makes your symptoms <u>better</u>? □ Rest □ Sitting □ Lying □ Standing □ Exercise/movement □ Elevation □ Ice □ Heat □ Compression/bracing □ Injections □ Pain pills/meds □ Past chiropractic care □ Other:_____

DC Name:_____

Do you have a headache/migraine? □ Y □ N **Location**:_____ **Light sensitive:** □ Y □ N **Sound Sensitive:** □ Y □ N

Nausea or vomiting: □ Y □ N **Change in vision/Aura**: □ Y □ N **Other**:_____

Name: _____ **DOB/Age:** _____

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REVIEW OF SYSTEMS

Have you recently had any of these symptoms? Please check all that apply or mark □ **NONE**

Skin
□Frequent Rashes
□Open Wounds
□Itchy/Red

Eye
□Blurred Vision
□Vision Loss
□Double Vision

Lung
□Short of Breath
□Wheezing
□Chronic Cough

ENT
□Hearing Loss
□Hoarseness
□Difficulty Swallowing

Digestive
□Heartburn
□Nausea/ Vomiting
□Blood in Stool

Blood
□Easy Bruising
□Easy Bleeding

Neuro
□Headaches
□Numbness
□Weakness
□Frequent Falls

Glands
□Excessive Thirst
□Frequent Urination
□Always Hot/Cold
□Lymphedema
□Thyroid Problems

Kidney/Bladder
□Painful Urination
□Kidney Problems
□Urinary Infections

Bones/Joints
□Osteoporosis
□Joint problems
□Broken Bones
□Fractures

Const
□Recent Weight Loss
□Frequent Fever
□Loss of Appetite

Cardio
□Chest Pain
□Irregular Beat
□Calf Pain
□Swelling Feet/Ankle

Psych
□Drug Abuse
□Alcohol Abuse
□Depression
□Anxiety
□Other:_____

Past Medical History

List any other doctors and their specialty that you see: _____

Do you have a history of any of the following: (Please check all that apply)

Heart
□Open Heart
□Stents
□Heart Attack
□Pacemaker
□Defibrillator
□Implantable Device
□Arrhythmia

Digestive
□Heartburn
□Reflux
□Ulcers
□Dialysis/Grafts

Bones/Joints
□Broken
□Osteoporosis
Arthritis
□Osteo
□Rheumatoid
□_____

Psych
□Anxiety
□Depression

Kidney
□Infection
□Stones

Lung
□Asthma
□COPD
□Oxygen Dependent
□Emphysema
□Sleep Apnea
□CPAP/BiPAP

Glands
□Diabetes Type I
□Diabetes Type II
□Thyroid

Neuro
□Neuropathy
□Seizures

Current/Past Infection
□Pneumonia
□Hepatitis
□HIV/AIDS
□MRSA
□Vancomycin-resistant Enterococcus
□Other

Circulation
□Blood Clots
□Clotting Disorders
□High Blood Pressure
□Stroke
□High Cholesterol

Other
□Liver Disease
□Cancer/type _____
□ Other:_____

List Past surgeries and what year they occurred: □**NONE**

□ Appendectomy _____
□ Tonsillectomy _____
□ Adenoids _____
□ C-Section _____
□ Bypass _____
□ Heart_____
□ Gall Bladder _____
□ Tubes in Ears _____
□ Hernia Repair _____
□ Oral Surgery _____
□ Hysterectomy _____
□ Tubal Ligation _____
□ Mastectomy _____
□ Prostatectomy _____
□ Orthopedic Surgery _____
□ Carpal Tunnel_____
□ Other _____
□ Other_____

Name: _____ **Arndt Chiropractic Center, Inc.** **Date:** _____
DOB/Age: _____ **3359 Middle Rd Ste 1 | Bettendorf, IA 52722**

Current Medications, dose & frequency (list all prescription and over the county mediation/supplements):

□ NONE □Please see list on separate sheet (staff can make a copy of your current list)

Are you allergic to any medications? □Y □N If yes, please list below and the reaction (hives/stopped breathing/rash/swelling)

Other Allergies □ Latex □ Food □ Environmental □ Metal □ Other:_____

FAMILY HISTORY

□ Adopted & family medical history is unknown □ No significant medical history of any direct relatives

List any major medical problems (examples: Diabetes, Heart Disease, Cancer, Arthritis….) **of your direct relatives:**

Mother:_____ Father: _____

Grandparents:_____

Siblings: _____ Children: _____

SOCIAL HISOTRY

Do you use tobacco? □ No □ Quit- when?_____ □ Yes-How much?_____

Alcohol Use? □ No □ Yes- How much?_____

Are you currently working? □ Y □ N **Type of job**:_____ □ Disabled □Retired

Are you a student? □ N □ Y at _____ Grade level:_____ Participating in what sports?_____

Marital Status: □ Single □Married □Divorced □Widowed **Children:** □ Yes □ No

Are you pregnant? □ Yes- due date_____ □ No □ Unknown **First day of last menstrual period**:_____

Do you exercise? □ No □ Yes- What kind:_____ How often:_____

Patient Signature The information on this form is accurate to the best of my knowledge **Date**

ARNDT CHIROPRACTIC CENTER

3359 Middle Road Suite 1 | Bettendorf, IA 52722
563.332.2211

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, test, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand that in the event of radiographic testing that this office will have my radiographs interpreted by Tracey A. Littrell, BA, DC, DACBR, a chiropractic radiologist certified by the American Chiropractic Board of Radiology.

I understand, as with any healthcare procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

In the event that I cannot be present for treatment with my minor child, as their guardian, I hereby give permission for the physician and staff to treat my minor child in my absence.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this healthcare office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE.

PRINTED NAME OF PATIENT

SIGNATURE OF PATIENT DATE

WITNESS TO PATIENT'S SIGNATURE DATE

WHEN PATIENT IS A MINOR OR UNABLE TO CONSENT.

PRINTED NAME OF PATIENT

SIGNATURE OF AUTHORIZED PERSON DATE

RELATIONSHIP

Arndt Chiropractic Center, Inc.
3359 Middle Rd Ste 1 | Bettendorf, IA 52722
563.332.2211

HIPAA NOTICE OF PRIVACY POLICY

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.

REQUIRED USES AND DISCLOSURES:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, of for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare 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 healthcare 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 healthcare services to you, to pay your healthcare 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 healthcare and any related services. This includes the coordination or management of your healthcare with a third party.

Payment: Your protected health information will be used, as needed, to obtain payment for you healthcare services.

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 medical/chiropractic students, licensing and conducting or arranging for other business activities.

In the event, radiograph testing is performed; this office will release radiographs to be interpreted by Tracey A. Littrell, BA, DC, BACBR, a chiropractic radiologist certified by the American Chiropractic Board of Radiology.

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 drug administration (FDA) requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation research, criminal activity, military activity, and national security, workers' compensation, inmates.

YOUR RIGHTS: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protect health information.

You have the right to request a restriction of you protect health information. This means you may ask us not to use or disclose any part of your protected health information to family members or friends who may be involved in your case or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information. If your request is denied for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of the Notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in the Notice.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with this Notice of our legal duties and privacy practices with the respect to protected health information. If you have any objections to the form please ask to speak with the Doctor.

Signature below is only acknowledgement that you received this Notice of our Privacy Practices.

Signature: _____ Print Name: _____ Date: _____

ARNDT CHIROPRACTIC CENTER

LISA A. ARNDT, D.C.
3359 Middle Road Suite 1 | Bettendorf, IA 52722
PH 563.332.2211 | FAX 563.332.2210

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

ARNDT CHIROPRACTIC CENTER is a HIPAA-compliant clinic.

PATIENT INFORMATION

NAME: _____ **BIRTHDATE:** _____

ADDRESS: _____ **PHONE:** _____

CITY: _____ **STATE:** ____ **ZIP CODE:** _____

FACILITY/PERSON(S) TO RECEIVE RECORDS

NAME: _____ **PHONE:** _____

ADDRESS: _____ **FAX:** _____

CITY: _____ **STATE:** ____ **ZIP CODE:** _____

FACILITY/PERSON(S) TO RELEASE RECORDS

NAME: _____ **PHONE:** _____

ADDRESS: _____ **FAX:** _____

CITY: _____ **STATE:** ____ **ZIP CODE:** _____

By initialing (please do NOT check mark) the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

By placing my **INITIALS** in the applicable space next to the type of information, I authorize the following records to be released:

_____ Chart (Progress) Notes
_____ History and Physical
_____ Diagnostic/Lab Reports
_____ Radiological Studies/Radiology Reports
_____ Other
Forms received w/o initials will be returned

By placing my **INITIALS** in the applicable space next to the type of information, I understand and agree that this information will be disclosed:

_____ HIV/AIDS – related information
_____ Drug/Alcohol treatment and/or related information
_____ Genetic Testing information
_____ Mental Health information
_____ Smoking Cessation treatment and/or related information
Forms received w/o initials will be returned

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire at the end of the calendar year from the date of signing. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol/tobacco diagnosis, treatment or referral information.

_____ _____

(Signature of Patient/Legal Guardian) (Date)