

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name: _____ What would you like to be called? _____

Address: _____ City: _____

State: _____ Zip: _____ E-mail Address: _____

Home Phone: _____ Office Phone: _____ Cell Phone: _____

Sex: M F Age: _____ Date of Birth: _____ Social Security No: _____

Occupation: _____ Employer: _____

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

Single Married Widowed Divorced Partnered Name of Spouse _____

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

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

Spouse's Work Phone: _____ Spouse's Date of Birth: _____

How did you hear about our office? _____

Have you ever had chiropractic care before? No Yes Where? _____

How long ago was your last adjustment? _____

Reason for not returning: _____

Were the results satisfactory? No Yes N/A

Major complaints and symptoms — please be as specific as you can.

How do you believe your problem (pain) began? _____

When did you first notice this problem/pain? _____

Have you lost any work? No Yes Day and date you last worked _____

Have you ever had this condition before or a similar condition? No Yes

When? _____

Is this problem due to a work-related injury? No Yes

Is this problem due to a motor vehicle collision? No Yes

Do you have pain that wakes you out of a sound sleep? No Yes

Have you had any changes in bowel or bladder habits? No Yes

Do you have night sweats? No Yes

Have you lost or gained weight in the past year? No Yes

Have you been treated recently by a Medical Physician for this ailment? _____

Where? _____

Describe the type of treatment: _____

Family physician's name _____

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

Would you allow us to send a report to your family physician? No Yes

Harmony Chiropractic Center, Inc.
7430 West Central Ave; Suite E
Toledo, OH 43617
419-517-5055

FEMALE HEALTH HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Today's Date: _____

Birth Date: _____ Weight: _____ Height: _____ Occupation: _____

1. What is the reason for this visit?

2. List medications you are currently taking:

3. Any known drug allergies? _____

4. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

5. List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast,

6. Date of last pelvic/gynecological exam: _____ Last Pap Test: _____
 Last Mammogram: _____

7. Last thermography? _____ Unusual results? _____

8. List significant non-GYN health issues (diabetes, surgeries, etc.): _____

Lifestyle Indicators < = less than > = greater than

1. Do you use any of the following? (circle responses)

Alcohol	None	<2 drinks/day	>2 drinks/day
Coffee	None	<2 cups/day	>2 cups/day
Soda	None	<2 cans/day	>2 cans/day
Sweets/refined carbs		<twice/day	<twice/day

2. Do you smoke cigarettes/cigars or use nicotine gum? Yes No How much/often? _____

3. How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

4. How would you rate your stress handling? (1Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

5. How often do you exercise? never rarely sometimes regularly competitively

INSTRUCTIONS: Check either “Ongoing” or “Just w/ Period” for each problem that applies to you.
 Check both if the problem is ongoing and worse with your period. Then rate the severity.

SIGNS & SYMPTOMS	ONGOING	JUST W/ PERIOD	MILD	MODERATE	SEVERE	MORE INFORMATION
Mood swings						
Anxiety/Nervousness						
Overly Reactive/Short fuse						
Irritability						
Depression						
Lowered self-esteem/self-image						
Caretake others before yourself						
Sadness/Crying						
Foggy thinking						
Memory difficulties						
Fatigue						
Constant hunger						
Sweet cravings (carbs/chocolate)						
Caffeine/Stimulant cravings						
Salt cravings						
Headaches/Migraines						
Body/Joint Aches/Backache						
Weight gain or gain (circle)						
Water Retention						
Bloating						
Irritable Bowel						
Constipation						
Light colored stool						
Loose stool/Diarrhea						
Nausea/vomiting						
Acne						
Excessive facial hair						
Body/Head hair loss						
Dry skin/Brown spots						
Lowered/Heightened Libido						
Hot Flashes						
Night sweats						
Breast tenderness/swelling						
Nipple discharge						
Vaginal infections						
Urinary frequency or						
Incontinence						
Vaginal dryness						
Painful intercourse						

REPRODUCTIVE HEALTH HISTORY (Please fill-in or circle the appropriate answer)

1. Age at onset of menarche (first period): _____ Approximate date of onset: _____
2. Are you currently using method of birth control? Yes No
If yes, what method? _____
3. Are you, or have you used (please circle) oral, injected, patch or ring hormone contraceptive or used Emergency Contraception (aka "the day after" pill) Yes No
When and for how long? _____
4. Are you, or have you used an IUD? Yes No If yes, when and for how long? _____
What type of IUD did you use? copper plastic hormone other _____
5. Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.).

6. Have you used or are you currently using fertility treatments? Yes No
If yes, please explain. _____
7. Have you used, or are you currently using bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes No If yes, what hormone(s), dosage & for how long? _____

8. Have you ever been pregnant before? Yes No Age of Children: _____
Number of pregnancies: _____ Details/Complications: _____
Number of live births: _____
Miscarriages: _____
Premature births: _____
Cesarean births: _____
Stillbirths: _____
Abortions: _____
Ectopic Pregnancies: _____
9. If you have had a miscarriage, how many weeks pregnant were you? _____
10. Have you had an abnormal Pap test? Yes No Diagnosis/Reason: _____
Treatment and/or Medication: _____
11. Have you had a vaginal infection? Yes No If yes, what? _____
Treatment and/or Medication: _____
12. Any history of Ovarian cysts? Yes No Uterine Fibroids? Yes No
Fibrocystic Breasts? Yes No Endometriosis? Yes No
Polycystic Ovarian Syndrome (PCOS) Yes No

FOR CYCLING-AGE WOMEN (Please fill-in or circle the appropriate answer)

1. First Day of last menstrual period (LMP): _____ Have you had a tubal ligation? Yes No When? _____
2. Has there been any recent changes in your cycle or symptoms associated with your cycle? Yes No
If yes, please give details. _____

3. How many days is your current cycle? (counted for the first day of your period to the first day of your next period)
<20 _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____
4. How many days does menstruation typically last? _____
5. Is your cycle regular? Yes No Not Always Details: _____
6. Typical Menstrual Flow: Light Medium Heavy Details: _____
7. How many pads and/or tampons (circle) are used on heavy days? _____
8. Do you pass clots? Yes No How Often? _____
9. Do you spot? Yes No At what point in your cycle? _____
10. Do you experience cramping? None Mild Moderate Severe
At what point in your cycle? _____
11. Do you experience abnormal vaginal discharge? Yes No If yes, when? _____
12. Do you experience vaginal itching and/or odor? Yes No If yes, when? _____
13. Do you experience breast tenderness? None Mild Moderate Severe
At what point in your cycle? _____ Change in breast size? Yes No
14. Do you experience nipple discharge? Yes No If yes, when? _____ Color? _____

FOR MENOPAUSAL WOMEN (please fill in or circle the appropriate answer)

1. Your age at the onset of menopause: _____ Year of onset: _____
2. Have you had a hysterectomy? No complete (ovaries AND uterus) partial (uterus only)
3. Date of hysterectomy: _____ Reason for hysterectomy: _____

4. List any other GYN related surgeries: _____

5. Describe your experience transitioning into menopause (symptoms, strong emotions, thoughts, unusual stressors, etc.)

MENOPAUSAL WOMEN, CONT'D

6. Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? Yes No
If yes, what were you prescribed? _____
What dosage? _____ For how long? _____
7. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? Yes No
If yes, what? _____
What dosage? _____ For how long? _____
8. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No
If yes, what? _____
For how long? _____
9. Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes No
If yes, when? _____ Were you evaluated/treated by a GYN? Yes No
Treatment: _____

PLEASE DESCRIBE YOUR CYCLE HISTORY.

10. How would you have described your menstruation?
Easy Uncomfortable Difficult Debilitating
11. What was your typical menstrual flow? Light Medium Heavy
12. When you were cycling would you consider your cycle regular? Yes No
If no, explain. _____
- Please describe any 'treatment' ever received for cycle issues. _____

SLEEP HABITS

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia
How long has this been happening? _____
2. How many hours do you sleep a night on average? _____
3. Do night sweats wake you up? Yes No How often? _____
4. Do you wake up tired? Yes No How long has this been happening? _____
5. Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) Yes No
Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

HARMONY CHIROPRACTIC CENTER, INC.

Patient Agreement

Your insurance plan, managed care program, or third party payor provides a *limited* range of benefits compared to the services available at this office. Your carrier provides coverage for “*medically necessary*” services as defined by them, for coverage or “*eligible*” benefits. In other words, no insurance carrier pays for everything. If possible, when the services you receive at this office exceed the covered or eligible benefit limits, or fall outside the payor’s definition of “*medically necessary*” we will attempt to inform you in advance. Please understand that it is virtually impossible to predict in advance, given the literally hundreds of plans in existence today, what the insurance company will or will not pay. We will certainly comply with our contractual obligations when they exist, and apply the “*appropriate*” write-offs and fee reductions, but we make no representation that all services will be covered. As such you are responsible for anything not covered by the carrier that exceeds the benefits described in the insurance booklet provided by your employer or health carrier. We recommend you become familiar with your benefits so there are no surprises for either of us.

The following is a list of the services generally available at this office. Most insurances pay for spinal manipulation to some degree, but the benefits vary. The other services may or may not be covered. Again, check your insurance booklet for a listing of available benefits.

X-rays, exams, therapies, spinal manipulation, supplements, orthotics/pillows/supports, ice packs, x-rays or x-ray interpretation, maintenance or supportive care, physical therapy modalities, rehab, educational classes, and many other services too numerous to list here.

There are numerous reasons for possible denial by your insurance company. Examples include: No referral from primary care provider, care deemed “not medically necessary”, no prior authorization was obtained, treatment extends beyond initial allowance, etc. There are literally hundreds of reasons which your insurance company may give for denial of benefits. As always, we honor our contract with the carriers and apply the appropriate write-offs, but no insurance company pays for everything and you should be come familiar with your benefit package.

PATIENT AGREEMENT & ACCEPTANCE OF LIABILITY

As you know, our office participates with many third party payor programs and as a result it becomes virtually impossible to predict in advance your available benefits. By signing this agreement you acknowledge that *it remains your responsibility to understand your benefits*, and it remains our responsibility to *comply with any contract we have with certain carriers*. As such, we will apply the appropriate reductions and write-offs for “covered benefits” only. You must pay for all appropriate co-pays, deductibles, and non-covered benefits. Additionally, you agree that you have been notified that your carrier might deny payment for the services identified above. If your carrier denies payment for any reason, you agree to be personally and fully responsible for payment. If you do not have any insurance coverage, you agree that you are personally and fully responsible for payment.

Patient Name

Date

Patient Signature

Staff Signature

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HIPAA Notice of Privacy Practices

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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.

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.

1. 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 or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 or 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 admission.

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 students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school 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.

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Your Rights: 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, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this 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 physician believes 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 communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We do not provide patient information to other organizations.

You may have the right to have your physician amend your protected health information. If we deny your request 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 this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this 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. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

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