

FOR OFFICE USE ONLY:

Patient Number: _____

Doctor: _____

Insurance: _____

Emp. Initials: _____

NEW PCP:

PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records.****

Patient Name: Last _____ First _____ Date ____ / ____ / ____

Address: _____ City _____ State _____ Zip _____

Cell Phone: (____) ____ - ____ Home Phone (____) ____ - ____ Birth date ____ / ____ / ____ Age ____

Sex: ____ M ____ F Driver's License: _____ Patient Soc. Sec. # ____ - ____ - ____

Marital Status: S M D W Spouse's Name: _____ Referred by: _____

Person responsible for payment: _____ Patient Employed by: _____

Occupation: _____ Work Phone: (____) ____ - ____

Email: _____

Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email

Have you ever been to a Chiropractor before?: YES NO

Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation

CAUSATION:

The cause for your visit today was from (Select one):

- Unknown factors
- auto accident
- work injury
- other accident
- trauma
- illness
- aggravation of a congenital problem

Date of onset (if known): ____ / ____ / ____

OR (Select one):

- few days ago
- week ago
- couple of weeks ago
- month ago
- several months ago
- more than a year ago

Have you ever had this complaint before this onset? (circle one): Y N

If you circled yes, select the number of times:

- one
- two
- three
- four
- more than four times
- multiple times

Since the onset of this complaint, it has been (circle one):

- improving
- getting worse
- staying the same
- intermittent

Please add any other information about the primary complaint that may be helpful:

PATIENT'S INITIALS _____ DATE _____

CHIEF COMPLAINT:

Please select the answers that best describe your primary complaint for today’s visit. Choose MORE than one answer if appropriate.

WHERE is your WORST pain?

- back of the head
- forehead
- area behind the eye
- face
- neck
- shoulder
- arm
- hand
- fingers
- upper back
- chest
- low back and buttock region
- abdomen
- groin
- “tailbone”
- hip
- knee
- leg
- foot

What word(s) BEST describe(s) you pain?

- constant
- intermittent
- mostly on the right side
- mostly on the left side
- about equal on both sides
- radiating from the neck into the back of the head
- radiating from the neck into the shoulder
- radiating from the neck into the arm and hand
- radiating into the chest
- radiating into the abdomen
- radiating into the groin
- radiating into the buttock and thigh
- radiating into the entire leg and foot
- “shooting”
- “burning”
- “stinging”
- “crawling”
- “aching”
- “throbbing”

FAMILY HISTORY:

Please select the conditions that pertain to your IMMEDIATE family. Put “M” for mother, “F” for father and “S” for siblings.

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> PMS
<input type="checkbox"/> Acid Reflux (GERD)	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Polio
<input type="checkbox"/> Allergies	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Attacks	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rapid Heart Rate
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dislocated Joints	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Rectum Cancer
<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Duodenum Ulcer	<input type="checkbox"/> Hernias	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mid-Back Pain	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraine	<input type="checkbox"/> Spinal Disc Disorder
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Esophageal Cancer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Stomach Cancer
<input type="checkbox"/> Bone Cancer	<input type="checkbox"/> Fainting	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Stroke
<input type="checkbox"/> Brain Cancer	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast Soreness	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Irregular Bowel Habits	<input type="checkbox"/> Overweight	<input type="checkbox"/> Upper Back Pain
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Gouty Arthritis	<input type="checkbox"/> Irregular Menstruation	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Vision Problems

PATIENT’S INITIALS _____ DATE _____

REVIEW OF SYSTEMS:

If you have an issue in a section below, select your issue from the list. If you have no problems for a particular question, select the "No symptoms" box.

Do you have any ill feelings?

- No symptoms
- Decreased activity level
- Fever
- Chills
- Fatigue
- Night sweats
- Loss of appetite
- Weight loss
- Weight gain
- Loss of energy
- Uncontrolled sweating

Do you have any mental health problems?

- No symptoms
- Irritability
- Depression
- Disturbed sleep
- Suicidal thoughts
- Anxiety
- Nervousness

Do you have any trouble urinating?

- No symptoms
- Frequent urination
- Urgency
- Trouble stopping or starting stream
- Erectile dysfunction
- Nocturia
- Burning with urination
- Losing control/incontinence
- Bowel dysfunction
- Sexual dysfunction
- Hesitancy

Do you have trouble with your vision?

- No symptoms
- Blurred vision
- Double vision
- Vision loss
- Work glasses/contacts

Do you have any symptoms of heart trouble?

- No symptoms
- Chest pain
- Palpitations
- Fainting
- Shortness of breath
- Ankle swelling

Do you have any breathing problems?

- No symptoms
- Coughing
- Wheezing
- Shortness of breath

Do you have stomach problems?

- No symptoms
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Loss of bowel control

Do you have muscle or joint problems?

- No symptoms
- Joint pain
- Joint weakness
- Muscle weakness

Do you have any skin problems?

- No symptoms
- Rash
- Itching
- Dryness
- Lesions
- Open wounds/infection
- Hair/nail changes

Do you have any immunity problems?

- No symptoms
- Enlarged lymph nodes
- Hives
- Hay fever
- Persistent infections

Do you have any endocrine problems?

- No symptoms
- Diabetes
- Thyroid disorder

Do you have any neurological problems?

- No symptoms
- Seizures
- Abnormal sensory feelings in extremity
- Loss of memory

Do you have any bruising or bleeding problems?

- No symptoms
- History of anemia
- Abnormal bleeding
- Bruising
- Heat intolerance
- Cold intolerance

PATIENT'S INITIALS _____ DATE _____

SOCIAL HISTORY:

Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> separated <input type="checkbox"/> widowed				
# of Children: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10+				
Highest level of education: <input type="checkbox"/> not completed high school <input type="checkbox"/> high school graduate <input type="checkbox"/> a Masters degree <input type="checkbox"/> completed medical school <input type="checkbox"/> GED diploma or equivalent <input type="checkbox"/> an associates degree <input type="checkbox"/> a PH.D. <input type="checkbox"/> completed a doctorate program (other than medicine) <input type="checkbox"/> completed trade school <input type="checkbox"/> a bachelor's degree <input type="checkbox"/> completed law school				
Do you eat a well balanced diet? <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> occasionally <input type="checkbox"/> usually <input type="checkbox"/> regularly	Do you exercise? <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> occasionally <input type="checkbox"/> usually <input type="checkbox"/> regularly			
Types of exercises:				
running/jogging walking weightlifting yoga/Pilates group exercises swimming	baseball basketball football golf soccer tennis			
Do you drink alcohol? <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> frequently (more than 3 days per week) <input type="checkbox"/> daily				
Do you use tobacco products? <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> frequently (more than 3 days per week) <input type="checkbox"/> daily				
Have you ever used illegal drugs? <input type="checkbox"/> yes <input type="checkbox"/> no	Have you ever had a substance abuse problem? <input type="checkbox"/> yes <input type="checkbox"/> no			
If yes, which ones?	If yes, which substance(s)?			
acid angel dust cocaine crack crystal meth ecstasy heroin LSD marijuana opium phencyclidines	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border: 1px solid black; padding: 2px;">General: alcohol amphetamines anti-depressants cannabis crack/cocaine diet pills hallucinogens inhalants methamphetamine muscle relaxants nicotine opiates pain medications phencyclidines sleeping pills steroids</td> <td style="width: 50%; border: 1px solid black; padding: 2px;">Specific: adderall ambien beer celebrex celexa cigarettes cigars cocaine crack crystal meth ecstasy effexor flexeril hard liquor hydrocodone ibuprofen lorcet lortab</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;"> marijuana methodone naproxen paxil prozac ritalin skelaxin soma tramadol ultracet ultram vicodin vicoprofen vioxx zanaflex xanax zoloft </td> </tr> </table>	General: alcohol amphetamines anti-depressants cannabis crack/cocaine diet pills hallucinogens inhalants methamphetamine muscle relaxants nicotine opiates pain medications phencyclidines sleeping pills steroids	Specific: adderall ambien beer celebrex celexa cigarettes cigars cocaine crack crystal meth ecstasy effexor flexeril hard liquor hydrocodone ibuprofen lorcet lortab	marijuana methodone naproxen paxil prozac ritalin skelaxin soma tramadol ultracet ultram vicodin vicoprofen vioxx zanaflex xanax zoloft
General: alcohol amphetamines anti-depressants cannabis crack/cocaine diet pills hallucinogens inhalants methamphetamine muscle relaxants nicotine opiates pain medications phencyclidines sleeping pills steroids	Specific: adderall ambien beer celebrex celexa cigarettes cigars cocaine crack crystal meth ecstasy effexor flexeril hard liquor hydrocodone ibuprofen lorcet lortab			
marijuana methodone naproxen paxil prozac ritalin skelaxin soma tramadol ultracet ultram vicodin vicoprofen vioxx zanaflex xanax zoloft				
Have you ever had treatment for substance abuse? <input type="checkbox"/> yes <input type="checkbox"/> no				

PATIENT'S INITIALS _____ DATE _____

PAST SURGICAL HISTORY:

Please list any surgeries that you have had in the past and the date if known. Also include RIGHT or LEFT side of body where applicable.

- I have never had any previous surgery

PROCEDURE:

DATE:

CURRENT MEDICATIONS:

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)					
NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ALLERGIES:

Please list any allergies as well as your reaction to the allergen if known.

Environmental Allergies: _____
Food Allergies: _____
Medication/Drug Allergies: _____

PATIENT'S INITIALS _____ DATE _____

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient signature _____ Date _____

Authorization and Assignment

AUTHORIZATION TO BILL INSURANCE: I understand my insurance will be billed for services rendered at Total Health Systems.

AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. 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. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

MEDICARE ASSIGNMENT (if applicable): I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

ACKNOWLEDGMENT AND UNDERSTANDING: I hereby acknowledge; That if there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Health Systems PC, will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

SPECIAL CONSIDERATION: I understand that should I have a financial hardship and am unable to completely satisfy my deductible/copy/or coinsurance I will notify Total Health Systems, PC and a separate written contract will be created and signed.

Patient signature _____ Date _____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Total Health Systems, P.C. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient signature _____ Date _____

Parent/Legal guardian name (please print) _____

Guardian Signature _____ Date _____

TOTAL HEALTH SYSTEMS Multi-Specialty Clinic

Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Total Health Systems, P.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Time

Witness Signature

Date

43740 Garfield ● Clinton Township Michigan 48038 ● (586) 228-0270
28098 23 Mile Rd ● Chesterfield Township ● Michigan 48051 ● (586) 949-0123
30045 Harper Ave ● St Clair Shores ● Michigan 48082 ● (586) 772-8560
57911 Van Dyke Rd ● Washington Township ● Michigan 48094 ● (586) 781-0800
Fax (586) 228-9019

www.totalhealthsystems.com

TOTAL HEALTH SYSTEMS

Multi-Specialty Clinic

Chiropractic • Medical • Physical Therapy • Massage • Nutrition • Fitness

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

- X-Rays History Diagnosis Treatment Reports
 Other: _____

Purpose of Release

- For the purpose of treatment at the above health care facility.
 Other: _____

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Name of Person Organization

Name of Person Organization

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contacting the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure. **If you understand and agree with all of the above policies, please sign your name below.**

Patient or Legally Authorized Individual Signature

Date & Time

Print Patient's Full Name

Date of Birth (XX/XX/XXXX)

Witness Signature

Date

43740 Garfield ● Clinton Township Michigan 48038 ● (586) 228-0270
28098 23 Mile Rd ● Chesterfield Township ● Michigan 48051 ● (586) 949-0123
30045 Harper Ave ● St Clair Shores ● Michigan 48082 ● (586) 772-8560
57911 Van Dyke Rd ● Washington Township ● Michigan 48094 ● (586) 781-0800
Fax (586) 228-9019
www.totalhealthsystems.com