FOR OFFICE USE ONLY:
Patient Number: _____
Doctor: _____
Insurance: _____
Emp. Initials: _____

PRIMARY CARE:
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: _____ Emergency Contact #/Relationship: _____
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

CHIEF COMPLAINT: **Answer the questions as completely as possible. If a question does not apply, leave it blank.**

Reason for today's appointment (Annual physical, Lab work, Sick visit, etc): _____

How long have you had this problem?
Date: _____ or _____day(s) _____ week(s) _____ month(s) _____ year(s)

How do you think your problem began?
_____

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (50-75%) ☐ Occasionally (26-49%) ☐ Intermittently (0-25%)

Rate the severity of your symptoms:
☐ Mild ☐ Moderate ☐ Severe

What makes the symptoms worse?
_____

What makes the symptoms better?
_____

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

*****Please list any ADDITIONAL complaints that you have: (Other areas of pain, etc.)*****
_____

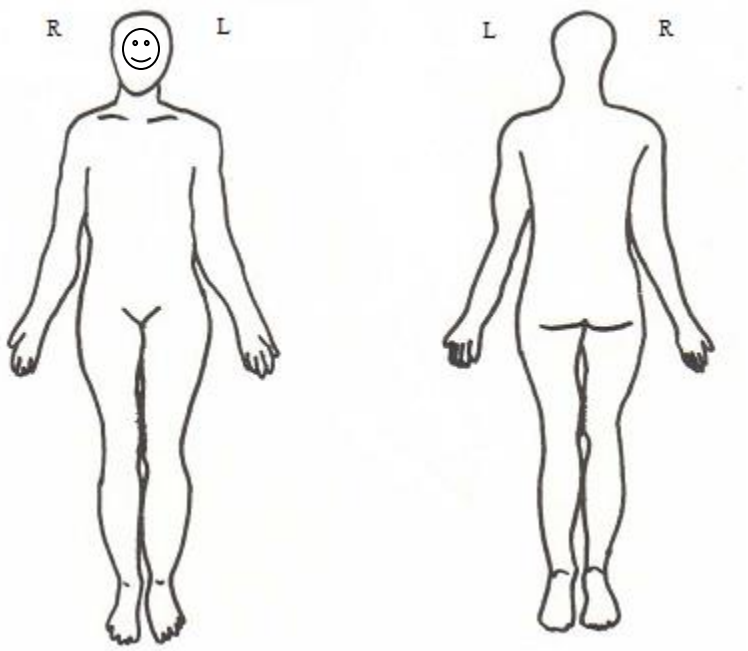
PATIENT'S INITIALS_____DATE_____

PAIN DRAWING:

INSTRUCTIONS: ***Mark the area on your body where you feel the described sensations:***

- ***Use the appropriate symbol***
- ***Mark the areas of spread***
- ***Include all affected areas***

KEY:	
Numbness / Tingling	**=======**
Pins & Needles	**oooooooo**
Burning pain	**xxxxxxxx**
Dull / achy pain	**……**
Sharp / Stabbing pain	**////////////////**



VISUAL PAIN SCALE

INSTRUCTIONS: ***Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, at its worst and at its best.***

Example:

Headache *Neck* *Low back*

No Pain **Worst pain**

0 (1) 2 3 4 (5) 6 7 8 (9) 10

What is your pain RIGHT NOW?

No Pain **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its BEST?

No Pain **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its WORST?

No Pain **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS: Please CIRCLE any condition that you CURRENTLY HAVE. Or check NONE ☐

ALLERGIC/IMMUNOLOGIC: ☐ **NONE** Food Allergies/sensitivities Seasonal allergies/Hay fever Hives

CARDIOVASCULAR: ☐ **NONE** Ankle swelling Blood clots Chest pain Feeling light headed with standing Heart murmur Heart problems High blood pressure High cholesterol Leg pain with walking short distances Low blood pressure Palpitations (heart skipping beats) Poor circulation Rapid heartbeat Sores that don't heal Varicose veins

CONSTITUTIONAL: ☐ **NONE** Chills Difficulty concentrating Difficulty sleeping Fatigue Fainting Fever Low libido Nervousness Night Sweats Poor appetite Weakness

EARS, NOSE &THROAT: ☐ **NONE** Blisters/cold sores Chronic ear infection Dental problems/toothaches Deviated septum Dry mouth Dysphagia/trouble swallowing Ear noises/ringing Ear pain Gum disease Hearing loss Loss of smell Loss of taste Loss of teeth/ have dentures Motion sickness Nose bleeds Nasal breathing problems Nasal drip Nasal polyps Recurrent ear infections Sinus infections/pain Sore throat/hoarseness Sores/ulcers Tonsillitis Vertigo/dizziness

ENDOCRINE: ☐ **NONE** A loss of appetite Being unusually jumpy or nervous Changes in hair growth or distribution Cold intolerance Excessive hunger Excessive thirst Feeling drowsy after eating Feeling shaky or faint when hungry Heat intolerance Hyperthyroid Hypothyroid Type I diabetes Type II diabetes Unexplained weight gain Unexplained weight loss

EYES: ☐ **NONE** Burning in the eyes Blurred vision Cataracts Dry or gritty eyes Far sightedness Glaucoma Itchy eyes Near sightedness Redness Swelling Tearing/crusting Vision headaches

GASTROINTESTINAL: ☐ **NONE** Abdominal gas Abdominal pain Acid reflux/heart burn Anorexia/Bulimia Constipation Diarrhea Discolored stool Frequent indigestion Gall bladder disease Hemorrhoids Liver disease Nausea Stomach Ulcers Vomiting

GENITOURINARY: ☐ **NONE** A discharge other than urine Bedwetting Bladder control problems Cloudy/foul smelling urine Difficulty starting a stream Discolored urine Dribbling Endometriosis Erectile dysfunction Frequent urination Getting up at night to urinate Infertility Kidney stones Kidney or bladder infections Painful urination PMS symptoms Urgency Uterine cysts Uterine fibroids

HEMATOLOGIC/LYMPHATIC: ☐ **NONE** Anemia Bleeding or bruising Blood clots Hemophilia Hepatitis A Hepatitis B Hepatitis C HIV/AIDS Jaundice Liver problems Lymphoma Myeloma Swollen Glands

INTEGUMENTARY/SKIN: ☐ **NONE** Acne Bruising Dandruff Dryness Eczema Excessive Sweating Nail fungus Plantar warts Psoriasis Rashes Skin cancer Sores

MUSCULOSKELETAL: ☐ **NONE** Arthritis Back pain/injuries General muscle tension Heel spurs Joint pain Joint stiffness Joint swelling Leg/foot cramps during the day Leg/foot cramps when retiring to bed or at night Muscle cramps Muscle pain Muscle Weakness Neck pain/ injuries Pain between the shoulders Painful feet Rheumatoid arthritis Scoliosis TMJ pain

NEUROLOGICAL: ☐ **NONE** Confusion Convulsions Difficulty of speech Double vision Epilepsy Fainting spells Headaches Incoordination Losing consciousness Loss of feeling Memory loss Meningitis Muscle jerking/twitching/tics Numbness/tingling Paralysis Pins/needles Seizures Stuttering

PSYCHIATRIC: ☐ **NONE** Alcoholism Anxiety Considerable emotional stress Crying often Depression Drug addictions/dependency Eating when nervous Extreme worry Feeling angered or irritable Hallucinations Insecurity Nail biting Phobias Recurrent bad dreams Sleep walking Suicidal thoughts

RESPIRATORY: ☐ **NONE** Apnea Asthma Congestion COPD Coughing up blood Difficulty breathing Emphysema Non-productive/dry cough Pneumonia Productive cough Shortness of breath Wheezing

FAMILY HISTORY: Please select the conditions that pertain to your family. (If known)

Relative:	Age: (if living)	Conditions/Illnesses:	Age at death:
Mother:	_____	_____	_____
Father:	_____	_____	_____

SOCIAL HISTORY: Please answer as completely as possible.

Marital Status: _____

Number of children: ____ Number of Pregnancies: ____ Number of miscarriages: ____ Number of abortions: ____

Highest level of education: _____

Do you feel that you eat a well-balanced diet? _____

How often do you exercise? _____ What types of exercises? _____

How often do you drink alcohol? _____

If you smoke cigarettes, how often? _____ If you chew tobacco, how often? _____

Have you ever used illegal drug? (circle) YES NO

If you use illegal drugs now, which ones? _____

Have you ever been treated for substance abuse? (circle) YES NO

Are your vaccinations up to date? (circle if known) YES NO

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:	PROCEDURE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Enviromental: _____
Food: _____
Medication/Drug: _____

CURRENT MEDICATIONS:

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

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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, PC.

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.

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.

ACKNOWLEGMENT 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/copay/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

26672 Van Dyke • Centerline • Michigan 48015 • (586) 756-7670
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
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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

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