Health History Form

Last Name: _____ First Name: _____ Date:_____/_____/_____

DOB:_____/_____/_____ Age_____ Gender: M / F SS#: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email address: _____

Occupation: _____ Employer's Name: _____

Single / Married / Divorced / Widowed Spouse's Name:_____

# of Children: (Names, Ages) _____

Who may we thank for referring you? _____

How long will you be in Naples? Seasonal Y or N? _____

What is most important to you when it comes to your experience here?

□ Time & Convenience □ Better overall health □ Get out of pain □ Be more active □ Figure out what is actually going on

□ Education & Expertise □ Wellness/Maintenance care □ Cost □ "Just crack my back Doc" □ "No cracking please!"

Main Health Concerns

Health Concerns: **In order of Severity**	**Rate of Severity** 1 = Mild 10 = Unbearable	**How long have you had this issue?**	**Did this start with an injury?**	**Have you had this before?**	**C = CONSTANT or C/G = Comes/Goes**
1. _____	1 2 3 4 5 6 7 8 9 10		**YES NO**	**YES NO**	**C C/G**
Describe the pain:	□ Sharp □ Soreness □ Throbbing □ Tingling □ Dull □ Stiffness □ Burning □ Ache □ Weakness □ Numbness □ Tingling □ Shooting □ Spasm □ Other:_____				
2. _____	1 2 3 4 5 6 7 8 9 10		**YES NO**	**YES NO**	**C C/G**
Describe the pain:	□ Sharp □ Soreness □ Throbbing □ Tingling □ Dull □ Stiffness □ Burning □ Ache □ Weakness □ Numbness □ Tingling □ Shooting □ Spasm □ Other:_____				
3. _____	1 2 3 4 5 6 7 8 9 10		**YES NO**	**YES NO**	**C C/G**
Describe the pain:	□ Sharp □ Soreness □ Throbbing □ Tingling □ Dull □ Stiffness □ Burning □ Ache □ Weakness □ Numbness □ Tingling □ Shooting □ Spasm □ Other:_____				
4. _____	1 2 3 4 5 6 7 8 9 10		**YES NO**	**YES NO**	**C C/G**
Describe the pain:	□ Sharp □ Soreness □ Throbbing □ Tingling □ Dull □ Stiffness □ Burning □ Ache □ Weakness □ Numbness □ Tingling □ Shooting □ Spasm □ Other:_____				

1. Does the pain travel anywhere else? □ YES or □ NO Describe:_____

2. Since it started, the pain has gotten: **better worse stayed the same**

3. What makes your health concern worse? □ Nothing □ Walking □ Standing □ Sitting

□ Exercise (moving) □ Lying Down □ Lifting □ Bending □ Other: _____

4. Have you seen anyone for this health concern? (Chiropractor, Medical Doctor, etc.) **YES NO**

If so, who? _____

5. How do your health concerns affect your daily life (brushing teeth, getting dressed, etc.)?

_____

6. Please list all medications, including vitamins/supplements, you are taking and for what?

_____

7. Please list any broken bones, surgeries, or hospitalizations you have had and when:

_____

8. Please list any auto accidents or major slips/falls/traumas you have been involved in:

_____

9. Spinal health is especially important during pregnancy; **<u>any chance</u> that you are pregnant**? YES NO

Due Date: ___/___/___

<u>Past Health History</u>

Please check all problems you have or have had now or in the past:

○ ADD/ADHD	○ Headache	○ Numbness in Arms
○ Anxiety	○ Heart Disorder/Disease	○ Numbness in Hands
○ Arm Pain	○ Hip Pain	○ Numbness in feet
○ Asthma	○ Infertility	○ Numbness in legs
○ Bladder Disorder	○ Irritable Bowel	○ Sciatica
○ Cancer	○ Kidney Problems	○ Scoliosis
○ Chest Pain	○ Knee Pain	○ Shoulder Pain
○ Chronic Fatigue	○ Leg Pain	○ Stomach Disorder/Disease Stroke
○ Chronic Sinus	○ Liver Disease	○ Throat issues
○ Disc Problem	○ Low Back Pain	○ Thyroid Problems
○ Dizziness	○ Lupus	○ TMJ
○ Ear Infections	○ Menstrual Disorder	○ Ulcers
○ Nausea	○ Mid Back Pain	○ Vertigo
○ Epilepsy	○ Migraines	○ Diabetes
○ Fibromyalgia	○ Neck pain	○ Other: _____
○ Gastric Reflux	○ Nervousness	

<u>Lifestyle:</u>

Exercise? □ None □ Moderate □ Daily	Smoking? **Yes** **No** Packs/Day _____	Coffee/Caffeine? **Yes** **No** Cups/Day_____
Work Activity? □ Sitting □Standing □ Light Labor □ Heavy Labor	Alcohol **Yes** or **No** Drinks/Day _____	Glasses of water/Day? _____

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

I have reviewed this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Daniel Taylor, D.C. and Jade Stevens D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices. A personal copy can be made available upon my request.

Printed Patient Name _____ Date _____

Signature _____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____

Patient Quality Of Life Survey Example

blueprint to Chiropractic

PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   - a. Medications
   - b. Emergency Room
   - c. Routine Medical
   - d. Exercise
   - e. Nutrition/Diet
   - f. Holistic Care
   - g. Vitamins
   - h. Chiropractic
   - i. Other (please specify): _____

2. How did the previous method(s) work out for you?
   - a. Bad results
   - b. Some results
   - c. Great results
   - d. Nothing changed
   - e. Did not get worse
   - f. Did not work very long
   - g. Still trying
   - h. Confused

3. How have others been affected by your health condition?
   - a. No one is affected
   - b. Haven't noticed any problem
   - c. They tell me to do something
   - d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - a. Job
   - b. Kids
   - c. Future ability
   - d. Marriage
   - e. Self-esteem
   - f. Sleep
   - g. Time
   - h. Finances
   - i. Freedom

Patient Quality Of Life Survey Example

blueprint to Chiropractic

5. Are there health conditions you are afraid this might turn into?

   a. Family health problems
   b. Heart disease
   c. Cancer
   d. Diabetes
   e. Arthritis
   f. Fibromyalgia
   g. Depression
   h. Chronic Fatigue
   i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

blueprint nutrition

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
Headaches and migraines

Hormone imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating and cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental and social concerns including:
Austism
ADD/ADHD

Skin Conditions: (urticaria)
Eczema
Skin rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire

	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____

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PATIENT'S NAME: _____ HR#: _____ Date: _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

PATIENT'S NAME: _____ HR#: _____ Date: _____

Naples Health Institute

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Naples Health Institute have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____
Patient Name (print)

_____ ____/____/____ ☐ *Witness Initials*
Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____
Patient Name (print)

_____ ____/____/____ ☐ *Witness Initials*
Patient or Authorized Person's Signature **Date**

PATIENT'S NAME: _____ HR#: _____ Date: _____

NAPLES HEALTH INSTITUTE
NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Dan Taylor (239-231-2136). If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness: _____ Date: _____