WELCOME TO OUR OFFICE

Confidential Patient Information

Name: _____ Date: _____

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

Phone (Home): (_____)_____ (Work): (_____)_____ (Mobile): (_____)_____

Email: _____ Referred By: _____

Age: _____ Birth Date: _____ Social Security No: _____ Sex: M / F Marital Status: S / M / W / D

Occupation: _____ Employer & Address: _____

Spouse's Name: _____ Spouse's Work Phone: (_____) _____Number of Children: _____

Emergency Contact: _____ Contact Phone: (_____) _____

Date of Last Physical Exam: _____ With Whom: _____ Where: _____

Reported Findings: _____

Surgeries, Hospitalizations, Serious Illnesses (List Year in Brackets): _____

_____

_____

_____

Fractures, Dislocations, Major Dental Work (List Year in Brackets): _____

Conditions You Have Had:

_ Allergies	_ Diabetes	_ Neck Pain	_ Sinus Troubles
_ Alcoholism	_ Digestive Disorders	_ Neuritis	_ Stroke
_ Anemia	_ Dizziness	_ Nervousness	_ Tuberculosis
_ Arthritis / Joint Pain	_ Epilepsy	_ Numbness	_ Ulcer
_ Asthma	_ Fatigue	_ Parasites	_ Urinary Trouble
_ Backaches	_ Headaches	_ Poor Appetite	_ Venereal Disease
_ Breathing Problems	_ Heart Trouble	_ Poor Circulation	_ Weight Loss
_ Cancer	_ High Blood Pressure	_ Prostate Problems	_ Yeast / Candida
_ Depression	_ Hypoglycemia	_ Rheumatic Fever	_ _____

Purpose of This Appointment: _____

_____

Other Doctors Seen For This Condition: _____

Have You Been Treated For Any Other Condition in The Past Year? Yes / No (If So, Describe): _____

_____

Medications / Drugs You Are Taking (state reason in brackets following drug): _____

_____

Remarks / Additional Information: _____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of Person Responsible for Payment: _____

Address & Phone (if different than yours): _____

PATIENT AGREEMENT: I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that I am personally responsible for payment, both for services when rendered and for missed appointments if I fail to give twenty-four hour advance notice of cancellation.

Signature: _____ Parent / Guardian Signature: _____ Date: _____

ADDITIONAL INFORMATION:

Height: _____ Weight: (Now) _____ (One Yr. Ago) _____ (Adult Maximum) _____ Age ____ (Adult Minimum) _____ Age ____
Known Allergies: _____

Blood Type: _____ Have You Ever Had a Blood or Plasma Transfusion? Yes / No

Habits:

Do You Smoke? Y / N What? _____ How Many / Day: _____ Since When? _____
Other Tobacco Products? Y / N What? _____ How Many / Day: _____ Since When? _____
Drink Coffee? Y / N Cups / Day _____ Drink Caffeinated Tea? Y / N Cups / Day _____
Colas / Soft Drinks? Y / N Number / Day _____ Glasses of Water / Day: _____
Alcoholic Beverages? Y / N Avg. No. / Wk _____ Mostly What? _____
Do You Eat Red Meat? Y / N Are You a Vegetarian? Y / N If So, For How Long? _____
Are You Dieting? Y / N If So, Describe: _____
Do You Eat in Fast Food Restaurants? Y / N If So, How Many Times / Week: _____
List Nutritional Supplements You Take: _____

Bowel Movement Frequency: _____ Difficulty? Y / N Approximate Number of Times You Urinate / Day: _____
Do You Sleep Well? Y / N If No, Describe: _____ Average Hours / Night: ____
Do You Have Sufficient Energy For Normal Activities? Y / N If No, Describe: _____

Do You Wear Corrective Lenses? Y / N What Is Your Uncorrected Vision? Right: _____ / 20 Left: _____ / 20
Has Your Vision Changed Recently? Y / N Explain: _____
Do You Wear Heel Lifts or Foot Supports? Y / N Explain: _____

Exercise:

What Sports Have You Played Seriously? _____
What Sports Do You Enjoy Now? _____
Are You In Training For a Particular Sport? Y / N Describe: _____
Do You Use a Heart Rate Monitor? Y / N If So, Target Range: _____
Describe Your Exercise Program: _____

XRAY HISTORY: (Include CAT, MRI, dye studies and dental) When was most recent x-ray / other study performed? _____

Age	Body Area	Type (Normal X-ray, CAT, MRI, etc.)	No. of Studies

FAMILY HISTORY:

	Living?	Age or Age At Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Other, Description
Father													
Father's Mother													
Father's Father													
Father's Grandparents													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Grandparents													
Mother's Siblings													
Your Siblings													
Your Children													

WOMEN ONLY: Menstrual History

Age at Onset: _____ Are Your Periods Regular? Y / N Cycle: _____ days (start to finish) Use Birth Control Pill? Y / N
Your Flow Is: heavy medium light Date of Last Period: _____ Cramping? Y / N
PMS? Y / N If So, What: _____
Other Menstrual / Hormonal Symptoms: _____

Dallas Chiropractic and Kinesiology

7515 Greenville Avenue ❖ Suite 904 ❖ Dallas, TX 75231 ❖ (214) 823-1323

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The primary treatment used is the spinal adjustment.
We may use this procedure to treat you.

1. THE NATURE OF CHIROPRACTIC ADJUSTMENT

We will use our hands or a mechanical device on your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sensation of movement.

2. THE MATERIAL RISK INHERENT IN CHIROPRACTIC ADJUSTMENT

As with many health care procedures, there are certain complications, which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner'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 serious complications, including stroke. Some patients feel some stiffness and soreness following the first few days of treatment.

3. PROBABILITY OF THOSE RISKS OCCURING

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during the examination and/or x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

I hereby authorize Dr. Christy Sutton and whoever is designated as assistants to administer chiropractic examination, treatment and/or x-rays as deemed necessary for my care.

Signature:_____ Date: _____

CONSENT TO TREATMENT OF A MINOR

I hereby authorize Sutton Chiropractic and Nutrition – Applied Kinesiology, Dr. Christy Sutton, and whoever is designated as assistants to administer chiropractic examination, treatment as deemed necessary to my child.

Name of Child:_____ Date:_____

Signature of Parent / Guardian:_____

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NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

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

Sutton Chiropractic and Nutrition – Applied Kinesiology, Dr. Christy Sutton has adopted the following privacy policies:

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of our office. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of the information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information may be used by our staff to notify you of appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your Protected Health Information;

2. The right to receive confidential communications concerning your medical condition and treatment;
3. The right to inspect and copy your Protected Health Information;
4. The right to amend or submit corrections to your Protected Health Information;
5. the right to receive an accounting of how and to whom your Protected Health Information has been disclosed; and
6. The right to receive a printed copy of this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy Protected Health Information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or your chiropractor.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to your chiropractor outlining your concerns at:

Dr. Christy Sutton
Sutton Chiropractic and Nutrition – Applied Kinesiology
7515 Greenville Avenue, Suite 904
Dallas, TX 75231

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concerns to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is Dr. Christy Sutton at the address above.

** HIPPA (Health Insurance Portability and Accountability Act) was signed into law on August 21, 1996, Public Law, 104-191. This was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security of health care information. It impacts all areas of the health care industry.

HIPPA – PRIVACY

I understand and agree to the Privacy laws, policies and procedures of Sutton Chiropractic and Nutrition – Applied Kinesiology.

_____

Signature

_____

Date

Dallas Chiropractic and Kinesiology

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SIGNATURE PAGE

Please read the following documents:

- Consent to Chiropractic Treatment
- Notice of Privacy Practices

Sign your agreement on this form which will be a part of your records. You may keep the consent and HIPPA documents for your reference.

Thank you!

CONSENT TO CHIROPRACTIC EXAMINATION / TREATMENT

I hereby authorize Dr. Christy Sutton and whoever is designated as assistants to administer chiropractic examination, treatment and/or x-rays as deemed necessary for my care.

Signature:_____ Date: _____

HIPPA – PRIVACY

I understand and agree to the Privacy laws, policies and procedures of Sutton Chiropractic and Nutrition – Applied Kinesiology.

Signature:_____ Date:_____

CONSENT TO TREATMENT OF A MINOR (IF APPLICABLE)

I hereby authorize Sutton Chiropractic and Nutrition–Applied Kinesiology, Dr. Christy Sutton, and whomever is designated as assistants to administer chiropractic examination, treatment as deemed necessary to my child.

Name of Child:_____

Signature of Parent / Guardian:_____Date: _____