PESTA FAMILY CHIROPRACTIC

PATIENT HISTORY SHEET

Please fill in all appropriate spaces: **All information you give is confidential**

Date: _____

Name: _____ Referred By:_____
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: _____ Sex: _____ Age: _____ Marital Status: _____ # of Children: _____
Home Phone (_____)_____ Occupation: _____
Work Phone (_____)_____ Email Address: _____
Cell Phone (_____)_____ SSN: _____
Prior Chiropractic care? (Y) (N) How Long Ago? _____

Major Complaint: _____
Was this injury related to: ( ) work accident? ( ) auto accident? (If yes, date began:_____)

How did the condition begin? _____
How long have you had this condition? _____

Do you feel it is: ( ) Getting Better ( ) Getting Worse ( ) Staying the Same

What seems to make it feel better? _____
What seems to make it feel worse? _____
Have you lost work days? Yes ( ) No ( ) How Many? _____
Have you had this similar condition before? Yes ( ) No ( ) When? _____

Please place a mark through the line below where it most accurately represents the pain or discomfort level that you are feeling ***RIGHT NOW***.

No Pain _____ **Unbearable Pain**

Please place a mark through the line below where it most accurately represents the pain or discomfort level that you felt on ***AVERAGE*** during the past week.

No Pain _____ **Unbearable Pain**

Please place a mark through the line below where it most accurately represents the pain or discomfort level that you felt at it's ***BEST*** during the past week.

No Pain _____ **Unbearable Pain**

Please place a mark through the line below where it most accurately represents the pain or discomfort level that you felt at it's ***WORST*** during the past week.

No Pain _____ **Unbearable Pain**

____ Fractured Bones
____ Auto Accidents
a. ____ 0-1 yrs ago

b. ____ 1-5 yrs ago
c. ____ more than 5 yrs
____ Other Accidents/Falls
____ Knocked Unconscious
____ Back Curvature/Scoliosis
____ Mental or Emotional Disorders
____ Arthritis
____ Diabetes
____ Swollen or Painful Joints
____ Convulsions/Epilepsy
____ Skin Problems
____ Cancer
____ Ear Infections
____ Frequent Cold/Flu

____ Nervous
____ Tension
____ Depressed
____ Irritable
____ Anemia
____ Tremors
____ Light bothers eyes
____ Allergies
____ Sinus Problems
____ Light headed upon rising
____ Under stress
____ Crave sweets or salt

____ Trouble sleeping
____ Trouble concentrating
____ Loss of memory
____ Learning Disability
____ Mistake Sidedness (R from L)
____ Stutter
____ Dyslexia
____ Mood Changes
____ Lose Temper Easily

____ Menstrual Problems/PMS
____ Breast Lumps, Soreness, Discharge
____ Pregnant (now)
____ Fertility Difficulties

____ Headache
____ Neck Pain or Stiff - R or L
____ Numbness, Tingling or pains in arms, hands, Fingers - R or L
____ Jaw Pain or Click (TMJ) - R or L
____ Head seems to Heavy
____ Head & Shoulders feel Tired
____ Difficult Movement (specify type_____)
____ Shoulder Pain - R or L
____ Dizziness or Loss of Balance
____ Ringing in Ears - R or L
____ Hearing Loss - R or L
____ Fainting
____ Blurred or Double Vision - R or L
____ Upper Back Pain or Stiffness - R or L
____ Mid Back Pain or Stiffness - R or L
____ Low Back Pain or Stiffness - R or L
____ Numb, Tingling or Pain in Buttocks, Thighs, Legs, Feet, Toes - R or L
____ Pain with Cough, Sneeze or Strain at Stool
____ Hip Pain - R or L
____ Foot Trouble - R or L

____ Chest Pain
____ Asthma or other Lung Problems
____ Difficulty Breathing
____ Heart Problems
____ Stroke
____ High or Low Blood Pressure

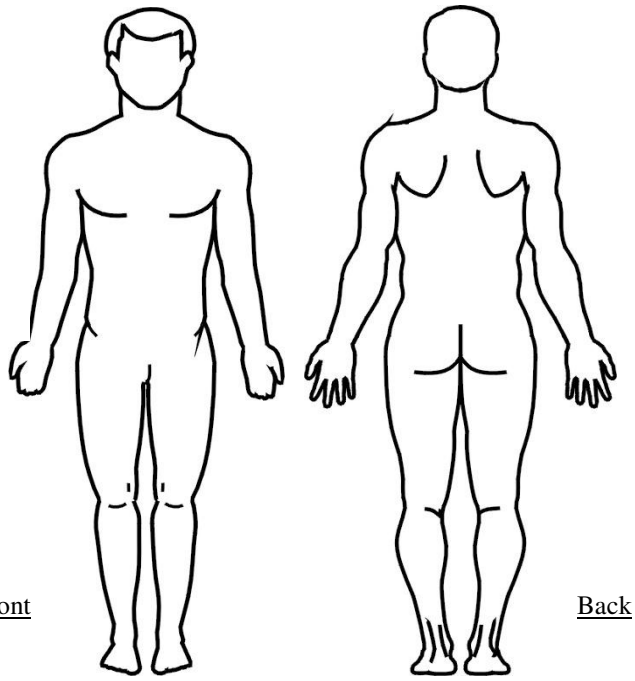
____ Liver Trouble
____ Digestive Problems
____ Excessive Gas
____ Belching/Bloating after Meals
____ Heartburn
____ Ulcers
____ Diarrhea/Constipation
____ Colon Trouble
____ Hemorrhoids
____ Prostate Problems
____ Impotence
____ Kidney Trouble/Stones
____ Frequent or Painful Urination

____ Hepatitis
____ Venereal Disease
____ AIDS/HIV

Please mark your areas of pain and/or numbness on the following figures:

Use multiple 'x's for areas of pain

Use multiple '—'s for areas of numbness



Front Back

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

____Temporary Relief ("just get me out of pain or out of crisis")
____Maximum Correction ("fix this problem so I can be healthy again")

WHAT ARE YOUR EXPECTATIONS OF US? _____
_____

Family History of:

Arthritis_____ Cancer_____ Diabetes_____ Heart Disease_____ Back Problems_____ Scoliosis (Back Curvature)____
List who in family with above conditions: _____

What surgeries have you had?_____

List drugs you now take (prescription / non-prescription and amounts):_____
_____

Are you wearing: Heel lifts? ( ) Arch supports? ( ) Last Dental check-up:_____
Last Eye Exam:_____ Last physical exam: _____

Habits:	Alcohol	Coffee	Tobacco	Rx Drugs	Exercise	Sleep	Appetite	Recreation	Sweets	Vit/Min Supplements
Heavy	_____	_____	_____	_____	_____	____	_____	_____	_____	_____
Moderate	_____	_____	_____	_____	_____	____	_____	_____	_____	_____
Light	_____	_____	_____	_____	_____	____	_____	_____	_____	_____
None	_____	_____	_____	_____	_____	____	_____	_____	_____	_____

- The statements made on this form are accurate to the best of my recollection & I agree to allow this office to examine me for further evaluation.
- I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination & treatment.
- I acknowledge receipt of "Notice of privacy policies"
- I understand that I am ultimately responsible for all fees for services rendered & that fees are payable when services are rendered.

Signature_____Date_____

PESTA CHIROPRACTIC
Dr. Michael J. Pesta, D.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED &DISCLOSED
& HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect May 1, 2013, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so, by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, texts, emails, Face Book message, postcards, or letters).

TESTIMONIAL: We may use your written testimonial/video testimonial for marketing purposes.

ADJUSTMENTS/TREATMENTS: Take place in an "open" setting. I understand there may be other patients/staff in this area. I understand my right to a private adjustment if requested.

FILES: My name may be displayed on files.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge you a cost-based fee for providing our health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before May 1, 2013. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. *You must make your request in writing* Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or if you have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health & Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Shelley Pesta, Office Manager
Telephone: 303 489-1349
Fax: 303 427-4760
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