CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____State: _____ Zip:_____ Work Phone: _____

DOB: _____Age: _____ Sex: M F Height: _____ Weight: _____

Your SSN: _____ Email Address:_____

How Did You Hear About Us? (Name of person or Company)_____

Spouses Name: _____ Number of Children: _____

Please circle: Single Married Divorced Separated Widowed Partnered

Business/Employer: _____ Type of Work: _____

Please list your chief health complaints, symptoms or concerns in the order of their severity below:

1. _____ How Long: _____
2. _____ How Long: _____
3. _____ How Long: _____

What is the main reason for your appointment today:_____

Is your condition due to a(n): Auto Accident Work Injury Maintenance Unknown Pregnancy

If due to an Auto or Work accident, please notify the front desk immediately for additional paperwork.

If Pregnant, How many weeks?_____ Girl or Boy Due Date _____

Who is your OBGYN/Midwife/Doula?_____

Date of Accident or Injury: _____Briefly Describe_____

Were you disabled from work? Yes No If yes, please give dates:_____

Date Symptoms Appeared: _____ Are they: Improving Getting worse
About the same Irregular

Circle the activities that aggravate your condition: Standing Walking Sitting Lying
Bending Lifting Twisting Coughing

Have you seen another doctor for this condition? Yes No

If yes, Dr. name: _____ Date Consulted:_____Diagnosis: _____

Have you ever had an MRI of your spine? Yes No

If yes, name of facility_____ Date of MRI: _____

Medications you currently take: _____

Please list any and ALL major accidents, injuries or falls you have had in your lifetime:

_____

_____

_____

Date:

Name: _____ Date: _____

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, as these problems can affect your overall course of Your Care.

PLEASE CHECK ANY OF THE FOLLOWING DISEASES OR CONDITIONS YOU HAVE HAD:

__Pneumonia	__Mumps	__Influenza	__Anemia	__Eczema
__Rheumatic fever	__Small pox	__Pleurisy	__Auto immune disease	__Measles
__Polio	__Chicken pox	__Arthritis	__Heart disease	__Lumbago
__Tuberculosis	__Diabetes	__Epilepsy	__Thyroid	__Asthma
__Whooping cough	__Cancer	__Mental disorder	__HIV positive	__Kidney Stones

PLEASE CHECK THE LINE OF SYPTOMS YOU HAVE HAD IN THE PAST 6 MONTHS: ___
THEN CIRCLE THE SYMPTOMS YOU ARE EXPERIENCING AT THE PRESENT TIME: __Headaches

MUSCULO-SKELETAL SYSTEM
__Head Pain/ Problems
__Neck Pain/Problems
__Shoulder Pain/Problems
__Arm Pain/Problems
__Hand Pain/Problems
__Mid Back Pain/Problems
__Chest Pain/Problems
__Stomach Pain/Problems
__Low Back Pain/Problems
__Hip Pain/Problems
__Leg Pain/Problems
__Foot Pain/Problems
__Walking Pain/Problems
__Chewing/ Jaw Pain/Problems
__General Stiffness

NERVOUS SYSTEM
__Nervousness
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion / Depression
__Fainting
__Convulsions
__Cold/Tingling Extremities
__Muscle Cramping
__Stress

GENERAL SYSTEM
__Fatigue
__Allergies
__Fever
__Headaches
__Migraine Headaches
__Tension Headaches
__Sinus Headaches
__Loss of Sleep

GENETO-URINARY SYSTEM
__Bladder Trouble
__Painful/Excessive Urination
__Discolored Urine
__Bed-Wetting

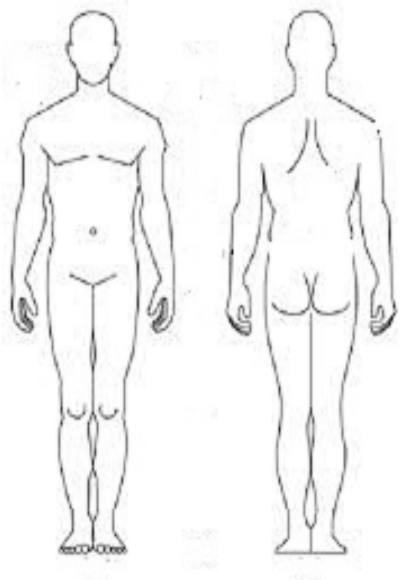
GASTRO-ENTESTINAL SYSTEM
__Poor/Excessive Appetite
__Excessive Thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids
__Liver Problems
__Gall Bladder Problems
__Heartburn/ Indigestion
__Black/ Bloody Stool
__Colitis

EARS, EYES, NOSE & THROAT
__Sinus Problems
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Aches
__Ringing in Ears
__Hearing difficulty
__Stuffed Nose

MALE/FEMALE
__Menstrual irregularity
__Menstrual cramping
__Vaginal pain/ infections
__Breast pain/lumps
__Prostate/sexual dysfunction

CARDIO-VASCULAR RESPIRATORY
__Chest Pain
__Shortness of Breath
__Blood Pressure Problems
__Irregular Heartbeat
__Heart Problems
__Lung Problems/congestion
__Varicose Veins
__Ankle swelling
__Stroke

DARKEN IN THE AREA OF YOUR PAIN OR DISCOMFORT ON THE DIAGRAM BELOW



Major Surgery or Operations you have had and dates:

_____

_____

Reasons for hospitalizations (other than above): _____

CONFIDENTIONAL PERSONAL HEALTH HISTORY

Name: _____ Date: _____

Daily Lifestyle and Habits: (Circle all that applies)

Alcohol	Daily	Weekly	Monthly	None
Coffee	>5 cups	2-4 cups	1 cup	None
Tobacco	>2 packs	1 pack	<1/2 pack	None
Drugs	Daily	Weekly	Monthly	None
Exercise	Daily	Weekly	Monthly	None
Sleep	>10 hrs.	7-10 hrs	1-7 hrs	<4 hrs.
Appetite	Heavy	Moderate	Light	None

FEMALES ONLY:

First day of last cycle: _____

Currently Pregnant? Yes No Maybe

Please Initial _____

Do you wear: ____Heal Lift ___Foot Pads ___Innersoles ___Arch Supports

DIET/NUTRITION:

Do you now take any vitamin or mineral supplements? Yes No

Do you think you may need vitamins or minerals? Yes No

Would you like a nutritional consultation as part of your personal care plan? Yes No

Insurance Information:

Do you want us to file with your insurance? Yes No

____Health insurance ___Medicare ___Medicaid ___Group ___Workers Comp ___Auto Accident

Name of insured:_____ Relationship to Patient: _____ SS# _____ DOB: _____

In case of an emergency, please give the name of a relative or close friend not living with you.

Name: _____ Relationship to patient: _____ Home Ph: _____

Address: _____ Work Ph: _____

PLEASE READ: I understand and agree by signing below that my health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment of these services in full. I also understand that if I suspend or terminate my care in this office, any and all outstanding charges fro professional services rendered to me will become immediately due and payable by myself personally at the full retail price. I also agree to pay any collection or legal fees that may occur if I do not pay my bill in a timely fashion and it is placed in collections.

Patient's Signature: _____ Date: _____

Parent or Guardian's Signature Authorizing Care: _____ Date: _____

HIPPA FORM

Use of this form is optional and not required under the HIPAA privacy rule.

Get Off My Nerves Chiropractic

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Get Off My Nerves Chiropractic, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Get Off My Nerves Chiropractic, LLC. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Get Off My Nerves Chiropractic, LLC. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Cathaleen Caillouet DC.

With this consent, Get Off My Nerves Chiropractic, LLC. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Get Off My Nerves Chiropractic LLC. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Get Off My Nerves Chiropractic LLC. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Get Off My Nerves Chiropractic LLC . restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Get Off My Nerves Chiropractic LLC. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Get Off My Nerves Chiropractic LLC. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient’s Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

Informed Consent for Chiropractic Treatment & Acknowledgment of Receipt of Information

To the patient: Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1) **Stroke:** Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise for the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive date to quantify probability.

2) **Disc Herniations:** Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors: Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.

3) **Soft Tissue Injury:** Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long-term affects for the patient.

4) **Rib Fractures:** The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from things as osteoporosis on their x-rays.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all of these matters. We have already discussed with you the common problems and risks. Please read this from carefully. Ask about anything you do not understand, and we will be pleased to explain it.

Informed Consent

I hereby authorize and direct Dr. Cathaleen Caillouet, together with associates and assistants of her choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustments, various modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

_____ _____

Patient's Name Date

_____ _____

Signature of patient or parent/guardian Witness

Get Off My Nerves Chiropractic
10979 Coursey Blvd. Suite J, Baton Rouge LA 70816
(225) 295-9993