ALVAREZ FAMILY CHIROPRACTIC, LLC
141 E. Indiana Ave, Ste B
Deland, FL 32724
Dr. Jackie Alvarez
Phone (386) 734-2522
Fax (386) 734-2502
Dr. Trevor Maxwell

Confidential Patient Health Record

DATE: _____

PERSONAL HISTORY

Name: _____ Address: _____

Home Phone: _____ City: _____ State: _____ Zip/Postal Code: _____

Cell Phone: _____ Birth Date: _____ Age: _____ Sex: Male or Female

Work Phone: _____ Social Security #: _____

Most Convenient way to reach you: • Home • Cell • Work E-Mail Address: _____

Confidential Communication Preference: • Home • Cell • Work • E-Mail • Postal Mail • In Person

Business Employer: _____ Type of Work: _____

Business Phone: _____ Marital Status: • Single • Married • Divorced • Widowed • Other

Name of Spouse: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ Business Phone: _____

Type of Work: _____ Name and Ages of Children: _____

Referred To This Office by: _____ _____

Name and Number of Emergency Contact: _____ **Relationship:** _____

Who is Responsible for Your Bill, • **You alone** or **You** and • **Spouse** • **Workers' Comp.** • **Auto Insurance** • **Medicare** • **Medicaid** • **Personal Health Insurance**

Name of Health Insurance _____ Health Card # _____

Second Insurance _____ Health Card # _____

GOVERNMENT REQUIREMENTS FOR ELECTRONIC HEALTH RECORDS

Preferred Language: • English • Spanish • French • German • Italian • Russian • Portuguese • Chinese • Japanese • Korean • Vietnamese

Race: • White • Black or African American • Other Race • American Indian or Alaska Native • Asian • More Than One Race • Native Hawaiian or Other Pacific Islander

Ethnicity: • Not Hispanic or Latino • Hispanic or Latino

Smoker: • Current Every Day • Current Some Days • Former Smoker • Never Smoked (under 100 per lifetime)

CURRENT HEALTH CONDITION

Reason for today's visit: _____

Is Condition: • Job Related • Auto Accident • Home Injury • Fall • Other: _____

Is patient pregnant • N/A • No • Yes Due date of baby _____ Is this your first baby • Yes • No How many other children _____

(For Job Related and Auto Accident, please advise staff and fill out accident form) Date & Time of Accident: _____

Other Doctors Seen for this Conditions: • YES • NO Who? _____

Type of Treatment: _____ Results: _____

When did this Condition Begin? _____ Has this Condition Occurred Before? • YES • NO

If this is work related: Have You Made a Report of Your Accident to Your Employer: • YES • NO • N/A

Do You Wear A Shoe Lift? • YES • NO

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: • Appendectomy • Tonsillectomy • Gall Bladder • Hernia • Back Surgery • Broken Bones • Other: _____

Major Accidents or Falls: _____

Hospitalization (Other than Above): _____

Previous Chiropractic Care: • None • Doctor's Name & Approximate Date of Last Visit: _____

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

REVIEW OF SYSTEMS- Please fill out all of the sections, even if "DENY"
CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Constitutional: I…. • Deny Any Constitutional Issue (s)
- Chills
- Fatigue
- Weight Gain
- Fever
- Daytime Somnolence (Drowsiness)
- Night Sweats
- Weight Loss

Eyes/Vision: I…. • Deny Any Eyes/Vision Issue (s)
- Blindness
- Blurred Vision
- Eye Pain
- Field Cuts (visual field defect)
- Tearing
- Wears Glasses/Contact Lenses
- Cataracts
- Glaucoma
- Change in Vision
- Itching (around eyes)
- Double Vision
- Photophobia

Ears, Nose & Throat: I…. • Deny Any Ears, Nose & Throat Issue (s)
- Bleeding
- Dizziness
- Sinus Infections
- Headaches
- Chronic Nasal Congestion
- TMJ Problems
- Snoring
- Head Injury
- Fainting
- Ear Drainage
- Ear Pain
- Loss of Smell
- Nose Bleeds (frequent)
- Post Nasal Drip
- Sore Throats (frequent)
- Dentures
- Discharge
- Hearing Loss
- Rhinorrhea (Runny Nose)
- Tinnitus (Ringing in Ears)
- Difficulty Swallowing
- Ear Pain
- Hoarseness

Respiration: I…. • Deny Any Respiration Issue (s)
- Asthma
- Cough
- Coughing Up Blood
- Shortness of Breath
- Sputum Production
- Wheezing

Gastrointestinal: I…. • Deny Any Gastrointestinal Issue (s)
- Abdominal Pain
- Difficulty Swallowing
- Nausea
- Abnormal Stool
- Belching
- Heartburn
- Rectal Bleeding
- Black, Tarry Stool
- Hemorrhoids
- Vomiting
- Constipation
- Indigestion
- Vomiting Blood
- Diarrhea
- Jaundice (Yellowing Skin)
- Abnormal Stool Color

Endocrine: I…. • Deny Any Endocrine Issue (s)
- Cold Intolerance
- Frequent Urination
- Voice Changes
- Diabetes
- Goiter
- Excessive Appetite
- Hair Loss
- Excessive Hunger
- Heat Intolerance
- Excessive Thirst
- Unusual Hair Growth

Nervous System: I…. • Deny Any Nervous System Issue (s)
- Dizziness
- Loss of Memory
- Stress
- Facial Weakness
- Numbness
- Strokes
- Headaches
- Seizures
- Tremors
- Limb Weakness
- Sleep Disturbances
- Unsteadiness of Gait
- Loss of Consciousness
- Slurred Speech

Allergy: I…. • Deny Any Allergy System Issue (s)
- Anaphylaxis (history of)
- Food Intolerance
- Itching
- Sneezing
- Chronic Nasal Congestion
- Acute Nasal Congestion

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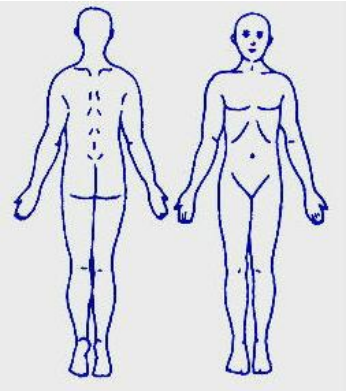
Please outline on the diagram the area of your discomfort

A= Aches B=Burning N=Numbness
P= Pins & Needles S= Stabbing O= Other



Cardiovascular: I…. • Deny Any Cardiovascular Issue (s)
- Angina (Chest Pain)
- Claudication (Leg Pain)
- Heart Murmur
- Heart Problems
- Swelling of Legs
- Orthopnea (difficulty breathing while lying down)
- Palpitations (irregular or forceful beating of heart)
- Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath)
- Shortness of Breath with Exertion or Exercise
- Ulcers
- Varicose Veins

Female: I…. • Deny Any Female Issue (s)
- Birth Control Therapy
- Breast Lumps/Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

Are you pregnant? • Yes Baby Due Date: _____
• No Date of Last Period: _____

Male: I…. • Deny Any Male Issue (s)
- Burning Urination
- Erectile Dysfunction
- Prostate Problems
- Urine Retention
- Frequent Urination
- Hesitancy/Dribbling

Skin: I…. • Deny Any Skin Issue (s)
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness,prickling,tingling)
- Rash
- History of Skin Disorder
- Skin Lesions/Ulcers
- Varicositites

Psychologic: I…. • Deny Any Psychologic Issue (s)
- Anhedonia
- Bipolar Disorder
- Mood Changes
- Confusion
- Convulsions
- Anxiety
- Depression
- Appetite Changes
- Insomnia
- Behavioral Changes
- Memory Loss

Hematology: I…. • Deny Any Hematology Issue (s)
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion
- Bruises Easy
- Fatigue
- Lymph Node Swelling

- I HAVE NOT HAD ANY OF THE DISEASES LISTED BELOW
- Pneumonia
- Mumps
- Influenza
- Rheumatic Fever
- Small Pox
- Pleurisy
- Polio
- Chicken Pox
- Arthritis
- Tuberculosis
- Diabetes
- Epilepsy
- Whooping Cough
- Cancer
- Lumbago
- Anemia
- Heart Disease
- Eczema
- Measles
- Thyroid
- Hepatitis Type: ____
- Mental Disorders

INTAKE
- Coffee
- Tea
- Alcohol
- White Sugar
- Cigarettes
- None of the above

Have you been tested for HIV? • Yes • No Test Results: • Positive • Negative

GOVERNMENT REQUIREMENTS FOR ELECTRONIC HEALTH RECORDS					
	Allergy # 1		**Allergy # 2**		**Allergy # 3**
Drug Allergy		Drug Allergy		Drug Allergy	
Onset Date		Onset Date		Onset Date	
Reaction		Reaction		Reaction	
Rx Norm#		Rx Norm#		Rx Norm#	
	Medication # 1		**Medication # 2**		**Medication # 3**
Generic Name		Generic Name		Generic Name	
Brand Name		Brand Name		Brand Name	
Strength (e.g.10mg)		Strength (e.g.10mg)		Strength (e.g.10mg)	
Dose		Dose		Dose	
Frequency		Frequency		Frequency	
How Taken		How Taken		How Taken	
Date Started		Date Started		Date Started	
Rx Norm#		Rx Norm#		Rx Norm#	
	Medication # 4		**Medication # 5**		**Medication # 6**
Generic Name		Generic Name		Generic Name	
Brand Name		Brand Name		Brand Name	
Strength (e.g.10mg)		Strength (e.g.10mg)		Strength (e.g.10mg)	
Dose		Dose		Dose	
Frequency		Frequency		Frequency	
How Taken		How Taken		How Taken	
Date Started		Date Started		Date Started	
Rx Norm#		Rx Norm#		Rx Norm#	
	Medication # 7		**Medication # 8**		**Medication # 9**
Generic Name		Generic Name		Generic Name	
Brand Name		Brand Name		Brand Name	
Strength (e.g.10mg)		Strength (e.g.10mg)		Strength (e.g.10mg)	
Dose		Dose		Dose	
Frequency		Frequency		Frequency	
How Taken		How Taken		How Taken	
Date Started		Date Started		Date Started	
Rx Norm#		Rx Norm#		Rx Norm#	

Should you need additional space for allergies or medications please ask the front desk for additional forms.

OUR PERSONAL PHYSICIANS
NAME AND CITY

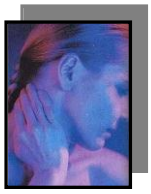
Family Doctor: _____
City, State: _____
Orthopedist: _____
City, State: _____
Neurologist: _____
City, State: _____
OB/GYN: _____
City, State: _____

Massage Therapist: _____
City, State: _____
Podiatrist: _____
City, State: _____
Dentist: _____
City, State: _____
Optometrist: _____
City, State: _____

I authorize Alvarez Family Chiropractic, LLC to provide medical records, including x-ray reports and any medical tests to the Physicians and Therapists listed above.

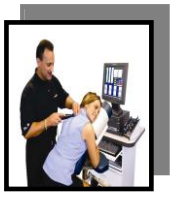
Patient Signature: _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.



Relief Care

Relief care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, But not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- **Relief Care**
- **Corrective Care**
- **Check here if you want the Doctor to select the type of care appropriate for your condition**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Printed Name_____

Patient's Signature _____ **Date:** _____

Parent or Guardian's Name _____

Signature of Parent
Authorizing consent to treat a Minor _____ **Date:** _____

Guardian or Spouse's
Signature of Authorizing Care: _____ **Date:** _____

Privacy Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy or your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Parties other than me that may have access to my protected health information are as follows: (please print)

_____relationship_____
_____relationship_____
_____relationship_____

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____ effective through December 31, 2013

_____
Patient's Printed Name

_____
Signature of Patient

_____
Parent or Patient's Representative's Printed Name

_____
Signature of Parent or Patient's Representative

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