CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license or other state issued identification and insurance card or details. We comply with all federal privacy standards. Please print clearly.

Canyon Creek Chiropractic
7109 S Highland Dr Suite-203
Cottonwood Heights, UT 84121
801-943-0932

Today's Date _____

Patient Number (office use only) _____

Patient Demographics

Last Name | **First Name** | **Middle Initial** | **Date of Birth** | **Sex**

Name Suffix | **Weight** | **Height** | **Employment Status** | **Professional Title**

Marital Status | **Sexual Orientation** | **Gender Identity** | **Preferred Language** | **Religion**

Ethnicity | **Racial Identity** | **Mother's Maiden Last Name** | **Mother's First Name**

Advance Directive Type

○ No Advance Directive ○ Living Will ○ Durable Power of Attorney ○ Do Not Resuscitate

Last Reviewed Date

Patient Contact Information

Address Line 1 | **Address Line 2** | **City** | **State** | **ZIP**

Home Phone | **Cell Phone** | **Work Phone & Employer Name** | **Preferred Phone**

○ Home ○ Cell ○ Work

Email Address

Communication Preference

○ Cell Phone ○ Email ○ Home Phone ○ Work Phone

Smoking History

Smoking History | **Frequency Per Day** | **Smoking Period Dates**

Additional Contact Information

Emergency Contact

Contact Name / Relationship | **Contact Address** | **City** | **State** | **ZIP** | **Phone**

Patient Insurance Information

Primary

Insurance Company | **Insurance Holder** | **Relationship to holder**

○ Self ○ Spouse ○ Child

Subscriber ID | **Group Number** | **Plan Name** | **$ Deductible**

Secondary

Insurance Company | **Insurance Holder** | **Relationship to holder**

○ Self ○ Spouse ○ Child

Subscriber ID | **Group Number** | **Plan Name** | **$ Deductible**

Symptoms

Reason for Visit _____ **When did you first notice the symptoms?** _____

Is this this condition getting progressively worse? _____

Where specifically is the problem located? _____

Which activities are difficult to perform? ○ Sitting ○ Standing ○ Walking ○ Bending ○ Lying down ○ Other

Type of pain: ○ Sharp ○ Dull ○ Throbbing ○ Numbness ○ Aching ○ Shooting ○ Burning ○ Tingling ○ Cramps ○ Stiffness ○ Swelling ○ Other

Rate the severity of your pain (1, mild pain or discomfort, to 10, severe pain) ○ 1 ○ 2 ○3 ○4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition? ○ Medication ○ Surgery ○ Physical Therapy ○ Other

Name and address of other doctor(s) who have treated you for your condition?

Health History – Check only those conditions which are applicable:

○ AIDS/HIV	○ Cataracts	○ Hepatitis	○ Osteoporosis	○ Suicide Attempt
○ Alcoholism	○ Chemical Dependency	○ Hernia	○ Pacemaker	○ Thyroid Problems
○ Allergy Shots	○ Chicken Pox	○ Herniated Disc	○ Parkinson's Disease	○ Tonsillitis
○ Anemia	○ Depression	○ Herpes	○ Pinched Nerve	○ Tuberculosis
○ Anorexia	○ Diabetes	○ High Cholesterol	○ Pneumonia	○ Tumors, Growths
○ Appendicitis	○ Emphysema	○ Kidney Disease	○ Polio	○ Typhoid Fever
○ Arthritis	○ Epilepsy	○ Liver Disease	○ Prostate Problems	○ Ulcers
○ Asthma	○ Fractures	○ Measles	○ Prosthesis	○ Vaginal Infections
○ Bleeding Disorders	○ Glaucoma	○ Migraine Headaches	○ Psychiatric Care	○ Venereal Disease
○ Breast Lump	○ Goiter	○ Miscarriage	○ Rheumatoid Arthritis	○ Whooping Cough
○ Bronchitis	○ Gonorrhea	○ Mononucleosis	○ Rheumatic Fever	○ Other
○ Bulimia	○ Gout	○ Multiple Sclerosis	○ Scarlet Fever	
○ Cancer	○ Heart Disease	○ Mumps	○ Stroke	

Dates of Last Exams and their findings: _____

(Women) Are you pregnant ○ Yes ○ No **Nursing** ○ Yes ○ No **Taking birth control pills?** ○ Yes ○ No

List any types of surgeries which you have had and the dates which they occurred

Please list all medications you are currently taking: _____

Allergies _____

Daily Habits

What type of exercise do you perform on a daily basis? ○ None ○ Moderate ○ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

What vitamins/supplements do you currently take?

How much alcohol do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage as indicated in the previous pages, and assign directly to Canyon Creek Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Canyon Creek Chiropractic may use my health care information and may disclose such information to the indicated insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Patient Signature (Printed)	Patient Signature	Patient ID (office use only)	Date

Canyon Creek Chiropractic - Dr. Malka Carlucci
7109 S Highland Dr Suite-203
Cottonwood Heights, UT 84121
801-943-0932

Authorization for Treatment

Documentation outlining risk of chiropractic procedures and authorization to physician for the providing of treatment

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Name: _____ Date: _____ Patient ID# _____

CHIROPRACTIC DISCLOSURE AND AUTHORIZATION OF TREATMENT

As with any medical procedure, patients have the right to understand the benefits and risks of treatment. Chiropractic physicians undergo extensive training, having the same level of education required of a medical doctor. Complications with treatment, however, are possible though exceedingly rare.

Chiropractic treatment includes the use of the physician's hands – or mechanical device – to facilitate the movement of your joints. You may feel a "click" or a "pop", such as the noise when a knuckle is "cracked", and you may feel the movement of the manipulated joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, and dry hydrotherapy may also be used in your treatment.

Risks with chiropractic treatment includes minor reactions such as some soreness or even bruising. A minority of patients may notice stiffness or soreness after the first few days of treatment and some ancillary procedures may produce skin irritation. Extensive complications have about the same numeric risk to an individual as taking a single aspirin tablet, which could include fracture of the bones, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or the spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. The risk of such occurring has been estimated to be one in one million, or one in twenty million – significantly reduced by the physician's careful screening during exam. Probability of adverse reaction to ancillary procedures is also considered "rare".

Other treatment options outside of chiropractic could be considered by patients, but these contain their own potential adverse risks. These could include the following:

- Over the counter analgesics – risks include irritation to the stomach, liver and kidneys, and other side effects
- Medical care – typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of such drugs include a multitude of undesirable effects and the potential of patient dependence
- Hospitalization – in conjunction with medical care, adding risk of exposure to virulent communicable disease
- Surgery – in conjunction with medical care, adds risk of adverse reaction to anesthesia, and extended convalescent period in a significant number of cases

Risks of remaining untreated or delaying treatment include the formation of adhesions, scar tissue, and degenerative changes, further reducing skeletal mobility, and inducing chronic pain. It is quite possible that delay will complicate existing conditions and make further rehabilitation more difficult.

I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Patient Name (Print)	(Patient Signature)	Date

HIPAA/Patient Rights Form

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information.

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Name: _____ Date: _____ Patient ID# _____

Uses and Disclosures of Health Information

We use the health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you may later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notices at any time.

Your Rights

Although your health record is the physical property of the health care practitioner or facility that compiles it, the information belongs to you. You have the right to:

- Request a restriction of certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Dr Malka Carlucci. You may also send a written complaint to the US Department of Health and Human Services. Dr Malka Carlucci can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. Questions or complaints can be direct to Dr Malka Carlucci at the address listed on this form.

I have read and received Canyon Creek Chiropractic's privacy summary and fully understand all of the information expressed within.

_____	_____	_____
Patient Name (Print)	(Patient Signature)	Date