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# Application for Care at Health From Within Dubuque

Today's Date:_____ HRN: _____

## PATIENT DEMOGRAPHICS

Name: _____ Birth Date:_____-_____-_____ Age: _____

Address:_____City:_____State:_____Zip:_____

E-mail Address: _____ Home Phone: _____ Mobile Phone:_____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____

Employer: _____ Occupation: _____

Spouse's Name_____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact:_____Relationship: _____

## HISTORY OF COMPLAINT

Please identify the symptom (s) that brought you to this office: Primarily: _____

Second:_____Third:_____Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by **circling the number:**

**Primary** or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Second** complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Third** complaint : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Fourth** complaint : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

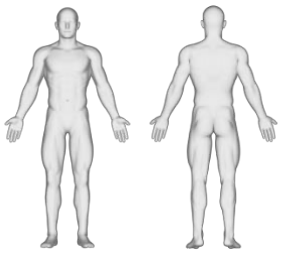
When did the problem(s) begin?_____When is the problem at its worst? ☐AM ☐PM ☐mid-day ☐late PM

How long does it last? ☐ It is constant ☐I experience it on and off during the day ☐ It comes and goes throughout the week

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes If yes, when: _____ by whom? _____

How long were you under care:_____ What were the results? _____

Have you seen a Chiropractor before: ☐ No ☐ Yes



***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms:
**R** = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T**= Tingling

What relieves your symptoms? _____
What makes them feel worse? _____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

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Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past? ☐ No ☐Yes **If yes** how many times? _____

When was the last episode?_____

Other forms of treatment tried: ☐ No ☐ Yes If yes, please state what type of treatment:_____,

How long ago?_____What were the results? ☐ Favorable ☐ Unfavorable

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the Past, **C** for Currently have or **N** for Never have had:

___ Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability____Cancer

___ Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular ___Other serious conditions:

**PLEASE Identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:**

| DATE | TYPE OF CARE RECEIVED | BY WHOM |
|---|---|---|
| INJURIES | | |
| SURGERIES | | |
| CHILDHOOD DISEASES | | |
| ADULT DISEASES | | |

**SOCIAL HISTORY**

**1.** Smoking ☐cigars ☐pipe ☐cigarettes How often? Daily Weekends Occasionally Never

**2**. Alcoholic Beverage Daily Weekends Occasionally Never

**3.** Recreational Drug use Daily Weekends Occasionally Never

**FAMILY HISTORY:**

**1.** Does anyone in your family suffer with the same condition(s)? ☐No ☐Yes

If yes whom: ☐grandmother ☐grandfather ☐mother ☐father ☐sister(s) ☐brother(s) ☐son(s)

☐daughter(s) Have they ever been treated for their condition? ☐No ☐Yes ☐I don't know

**2.** Any other hereditary conditions the doctor should be aware of? ☐No ☐Yes: _____

I hereby authorize payment to be made directly to Health From Within Dubuque for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Health From Within Dubuque for any and all services I receive at this office.

_____ ____-____-____

Patient or Authorized Person's Signature Date Completed

_____ ____-____-____

Doctor's Signature Date Form Reviewed

Patient's Name: _____ HR#: _____ ___/___/___ JDD,DC 5/2011

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# Activities of Daily Living/Symptoms/Medications

Patient Name: _____ Date: _____ File#_____

## Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| | | | | |
|---|---|---|---|---|
| Bending | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Concentrating | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Doing computer Work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Gardening | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Playing Sports | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Recreation Activities | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Shoveling | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sleeping | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Watching TV | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Carrying | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Dancing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Dressing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Lifting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Pushing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Rolling Over | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sitting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Working | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Climbing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Doing Chores | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Performing Sexual Activity | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Reading | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Running | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sitting to Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |

**Please mark P for in the Past, C for Currently have or N for Never**

| | | | | |
|---|---|---|---|---|
| ___ Headache | ___ Pregnant (Now) | ___ Dizziness | ___ Prostate Problems | ___ Ulcers |
| ___ Neck Pain | ___ Frequent Colds/Flu | ___ Loss of Balance | ___ Impotence/Sexual Dysfunction | ___ Heartburn |
| ___ Jaw Pain, TMJ | ___ Convulsions/Epilepsy | ___ Fainting | ___ Digestive Problems | ___ Allergies |
| ___ Shoulder Pain | ___ Tremors | ___ Double Vision | ___ Colon Trouble | ___ High Blood Pressure |
| ___ Upper Back Pain | ___ Chest Pain | ___ Blurred Vision | ___ Diarrhea/Constipation | ___ Low Blood Pressure |
| ___ Mid Back Pain | ___ Pain w/Cough/Sneeze | ___ Ringing in Ears | ___ Menopausal Problems | ___ Asthma |
| ___ Low Back Pain | ___ Foot or Knee Problems | ___ Hearing Loss | ___ Menstrual Problems | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Sinus/Drainage Problem | ___ Depression | ___ PMS | ___ Lung Problems |
| ___ Back Curvature | ___ Swollen/Painful Joints | ___ Irritability | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disability | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | | ___ ADD/ADHD | ___ Eating Disorder | ___ Liver Trouble |
| | | | ___ Trouble Sleeping | ___ Hepatitis (A,B,C) |

List Prescription & Non-Prescription drugs you take:_____

_____

_____

JDD,DC 5/2011

**Informed Consent Document**

PATIENT NAME: _____

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health is you choose not to receive the care.
Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment.**

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. The doctor may use my hands or a mechanical instrument upon 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 sense of movement.

**The risks inherent in chiropractic adjustment.**

It is important that you understand, as with all health care approaches, results are not guaranteed and there is no promise to cure. As with all types of health care interventions, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, 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 will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

**The availability and nature of other treatment options.**

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measure and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

**The risks and dangers attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

# Consent to Treatment

**REGARDING: Analysis / Examination / Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures that will be done by the doctor or other members of the staff:

_____ spinal manipulative therapy _____ palpation _____ vital signs _____ orthopedic testing

_____ range of motion testing _____ basic neurological testing _____ postural analysis testing

_____ radiographic studies _____ Other (please explain):

_____

_____

_____ Initial

**REGARDING: X-rays/Imaging Studies**

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case

_____ Initial

**MINORS ONLY**

I hereby request and authorize Dr. Abigail Tebbe to preform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select to authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way. I will immediately notify this office.

_____ Initial

**FEMALES ONLY**: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of your last menstrual cycle was on ___/___ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

_____ Initial

PLEASE CHECK THE APPORPRIATE BLOCK AND SIGN BELOW.

**I have read or, it has been read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved, I've asked my questions and have had them answered to their satisfaction (if applicable). I have decided that it is my best interest to undergo the treatment recommended. I hereby give my consent to that treatment.**

_____ ___/_____/_____

Patient or Authorized Person's Signature Date

_____ ___/_____/_____

HFW Staff Signature Date

# Health From Within Dubuque

## NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

**PERMITTED DISCLOSURES:**

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or the general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls, text or emails and appointment reminders -we may call or text your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost

**COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call Dr. Abby Tebbe at 563.556.6252 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

JDD,DC 5/2011

**Patient initials**: _____

## Health From Within Dubuque Chiropractic's

### NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Health From Within Dubuque 's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

| Patient's Name | DOB | HR# |
|---|---|---|

| Patient signature | Date |
|---|---|

| Witness | Date |
|---|---|

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