

Dr. David Cox

Sound Health Chiropractic
1218 29th Street, Suite B • Anacortes, WA 98221

360/299-4500

HEALTH REPORT

NAME: _____ DOB: _____ DATE: _____

Reason for seeking care: _____

List any other doctors/therapists seen for this: _____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? Yes No If yes, explain: _____

Have you received chiropractic treatment previously? Yes No

If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, explain: _____

Are you currently taking medication? Yes No List medications: _____

Have you taken medication in the past? Yes No List medications: _____

List conditions you are taking medications for: _____

List the approximate dates of any surgery or treated conditions: _____

Family History: Health conditions, age of death and cause of death.

Father: _____

Mother: _____

Brother/s & Sister/s: _____

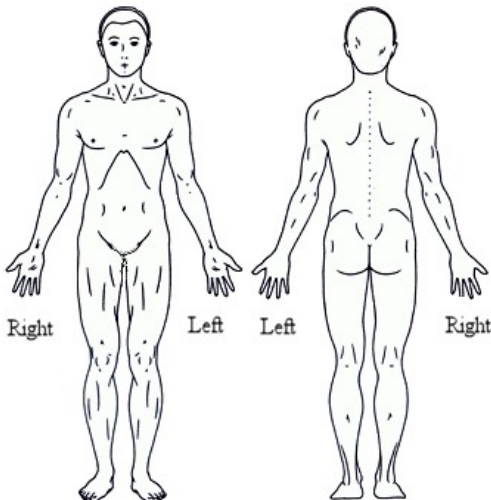
Do you smoke Y/N • Alcohol Y/N Daily Weekly Social Occasions • Caffeinated drinks per day _____

Do you take Vitamins/Supplements Y/N If yes, type and how often _____

Please circle degree of pain, 0 = none, 10 = severe: 0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel:

- Numbness = = =
- Dull Ache OOO
- Burning XXX
- Sharp/Stabbing ///
- Pins and Needles + + +
- Other _____ ^ ^ ^



What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? Y / N

Is this condition interfering with Work? _____ Sleep? _____

Routine? _____ Other? _____

Is this condition progressively getting worse? _____

Do you experience pain with: Standing • Walking • Sitting •

Bending • Lying down • Lifting • Sports • Other _____

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**Please mark each item below for each sign or symptom
you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between
Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma

- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy

FOR WOMEN ONLY

- Birth Control _____
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____



Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ **Last Name:** _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (*These summaries are often blank as a result of the nature and frequency of chiropractic care.*)

Patient Signature: _____ **Date:** _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

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NOTICE: PATIENT PRIVACY

Effective Date: March 25, 2010

We are committed to preserving the privacy of your personal health information and are, in fact, required by law to protect this information and to provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purpose of providing or arranging for your health care, the payment for reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date noted on this form indicates the most current notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current notice, please feel free to ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our office.

Thank you,

Dr. David Cox

I have read and understand this document. Initial: _____ Date: _____

Disclaimer: This document and the information in it does not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPAA regulations.

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain that goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation and skeletal misalignment. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

I therefore accept chiropractic care on this basis.

(signature)

(date)