BAHAN NATURAL HEALTH CENTER

Patient Information

Date

Patient Name

Address **State** **Zip**

Phone Number

Email

Sex

- [ ] Male
- [ ] Female

Age

Date of Birth

Occupation

Employer

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed
- [ ] Separated
- [ ] Partnered for __ years
- [ ] Minor

Emergency Contact Name

Emergenct Contact Phone Number

Please list any allergies

What services are you interested in?

- [ ] Chiropractic
- [ ] Nutrition
- [ ] Counseling
- [ ] Sports Injury

Reason for Visit

How did you hear about the Center?

BAHAN NATURAL HEALTH CENTER

Patient History

What treatments have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services

☐ None ☐ Other:_____

Primary Care Physician

Address **State** **Zip**

Please circle YES or NO to indicate if you have had any of the following conditions:

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

BAHAN NATURAL HEALTH CENTER

Patient Lifestyle

How would you describe your exercise routine?

☐ None ☐ Light ☐ Moderate ☐ Daily ☐ Heavy

How would you describe your work activity?

☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Cigarettes per day **Alcohol per day** **Caffeine per day**

Do you have a high stress level? If so, why?

Are you pregnant? **Due Date**

☐ Yes ☐ No

Injuries / Surgeries you have had (please describe) **Date**

☐ Falls

☐ Head Injury

☐ Broken Bone

☐ Dislocation

☐ Surgery

Please list all Medications, Vitamins, Herbs, Supplements, and Minerals you are currently taking

Patient / Guardian Signature **Date**

BAHAN NATURAL HEALTH CENTER

Office Policy

We want you to know your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operation we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA Notice that is available to you at the front desk before signing this consent.

1. *The patient understands and agrees to allow this Chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment payment, health care operations, and coordination of care.*
2. *The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know that disclosures have been made and submit in writing any further restriction on the use of their PHI. Our office is not obligated to agree to those restrictions.*
3. *A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.*
4. *The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.*
5. *For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.*
6. *Patients have the right to file a formal complaint with our privacy official about any possible violation of these policies and procedures.*
7. *If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse the given care.*

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient / Guardian Signature **Date**