



INTEGRATIVE HEALING ARTS

ANNE C. ROULO, DC

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314.644.2070

Date _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ - _____ - _____

Home Phone: (____) _____ Cell Ph.: (____) _____ Work Ph.: (____) _____

Gender: M F Date of Birth: _____ Age: _____

Marital Status: S M D W Work Status: Full time Part time Retired

of Children _____

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Name of Spouse or Partner. For Minors, Name of Parent or Guardian:

Age: _____ Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: (____) _____

In case of emergency contact: _____

Relationship: _____

Do you have Medicare insurance? Y N Plan/Group #: _____

List chiropractors you have seen previously _____

How did you find us, and may we thank someone for referring you? _____

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations 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 HIPAA 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, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

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 what disclosures have been made and submit in writing any further restrictions 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 the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect 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 has 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 violations 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 to give care.

I have read and understand how my PHI will be used and I agree to these policies and procedures:

Signature: _____ Date: _____

(Medicare Patients Only) Waiver of Liability/Advance Beneficiary Notice
Includes all services.

Provider Notice: Medicare will only pay for services that are determined to be “reasonable and necessary” under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not “reasonable and necessary” under Medicare program standards, Medicare will deny payment for that service.

Beneficiary Agreement: “I have been notified by my provider that he/she believes that Medicare may deny payment for service. If Medicare denies payment, I agree to be personally and fully responsible for payment”.

Signature: _____ Date: _____

I understand that payment is due in full at time of service unless prior arrangements have been made. Fees are based on upon individual services and may vary from visit to visit.

I agree to pay in full at the time of service and will file my own insurance. Reimbursement is determined by my contract with my insurance company.

Signature: _____ Date: _____

Health History:

Habits:

Drinks/day

Alcohol _____

Soda/diet soda _____

Coffee/tea _____

Sweetener _____

Water intake 64+ oz 32-64 oz
 (per day) 16-32 oz 8-16 oz
 < 8 oz

1 glass = 8-12 oz

Tobacco: Packs/day _____

Stress level: High Mod Low

Sleep: 8+ hrs 6-8 hrs 4-6 hrs < 4 hrs

Exercise: 5-7x/wk 3-5x/wk 1-3x/wk
 none Type _____

Meals/day: 5 4 3 2 1

Veggies and fruits/day: 5 4 3 2 1

- Do you feel your diet is adequate? Y N
- Has your diet affected your quality of life? Y N
- Are you on a special diet or particular diet? Y N If yes explain _____
- How long has it been since you felt really good? Days Weeks Months Years >10 years
- What is your general state of health? Excellent Good Fair Poor
- Please rate how serious you are about getting well (scale of 1 -10) _____
- Please rate how serious you are about staying well (scale of 1 -10) _____
- Are you willing to follow a treatment plan designed to help you return to health? Yes No
- Are you willing to take supplements and make dietary changes? Yes No

Work Activity:

- Heavy labor Light Labor Mostly Sitting Mostly Standing Driving Walking

Medications: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
<input type="checkbox"/> Antacids	_____	_____
<input type="checkbox"/> Antibiotics	_____	_____
<input type="checkbox"/> Anti-depressants	_____	_____
<input type="checkbox"/> Anti-diabetics	_____	_____
<input type="checkbox"/> Anti-inflammatory	_____	_____
<input type="checkbox"/> Blood pressure lowering meds	_____	_____
<input type="checkbox"/> Cholesterol lowering meds	_____	_____
<input type="checkbox"/> Hormone Replacement (HRT)	_____	_____
<input type="checkbox"/> Oral contraceptives	_____	_____
<input type="checkbox"/> Over-the-Counter	_____	_____
<input type="checkbox"/> Other	_____	_____
<input type="checkbox"/> Other	_____	_____

Do you take vitamins/supplements or herbs? Y N

Please list: _____

Allergies: Please list all allergies.

- Food: _____
- Medications: _____
- Seasonal/Other: _____

Surgical Procedures/Scars: List all major surgeries, date performed, and scar location. _____

Hospitalizations: Describe reason for hospitalization, date, and treatment. _____

Automobile Accidents: List date, injuries, and treatment. _____

Other Accidents: Describe accident (eg. fractures, dislocations, bad falls, sprains, head injuries). _____

Please give the most recent date: Lab work: _____ Radiographic study and body part: _____

Physical exam: _____ Females: Pap smear and breast exam: _____

Please mark with an "S =self" any illnesses that you have now or have had in the past. Also, identify any conditions your family members have now or have had in the past. G = Grandparents, M = Mother, F = Father.

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Muscle disorders |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Anemia or other blood disorder | <input type="checkbox"/> Immune system problems |
| <input type="checkbox"/> Diabetes or hypoglycemia | <input type="checkbox"/> Tumors: non-cancerous |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Colon disease | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Deep vein thrombosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pneumonia | |

Symptoms: Please mark "P" (past) or "C" (current), and circle any that are of particular concern to you.

General

- Convulsions
- Confusion
- Dizziness
- Fatigue
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats
- Weakness in limbs
- Fever

Muscles and Joints

- Twitching
- Stiff Neck
- Backache
- Swollen Joints
- Tremors
- Foot Trouble
- Painful Tailbone
- Pain between Shoulders
- Hernia
- Spinal Curvature

Gastro-intestinal

- Poor Appetite
- Poor Digestion
- Excessive Hunger
- Belching
- Foul Gas
- Nausea
- Vomiting
- Vomiting or Blood

Women Only

- Painful Periods
- Excessive Flow
- Irregular cycle
- Hot Flashes
- Cramps or Backache
- Miscarriage
- Vaginal Discharge
- Fertility Problems

Pregnant? Yes No

Nursing? Yes No

- Pain Over Stomach
- Constipation
- Diarrhea
- Colon Trouble
- Hemorrhoids
- Liver Trouble
- Jaundice
- Gall Bladder Trouble

Cardiovascular

- Rapid Heart
- Slow Heart
- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Stroke
- Poor Circulation
- Ankle Swelling
- Hardening of Arteries

EENT

- Poor Vision
- Crossed Eyes
- Pain in Eyes
- Deafness
- Earache
- Ear Noises
- Ear Discharge
- Nasal Obstruction
- Nose Bleeds
- Sore Throats
- Horseness
- Hay Fever

- Asthma
- Frequent Colds
- Enlarged Thyroid
- Tonsillitis
- Sinus Trouble

Skin

- Skin Eruptions
- Itching
- Bruise Easily
- Dryness
- Boils
- Sensitive Skin
- Eczema
- Varicose Veins

Respiratory:

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

Genito-urinary

- Frequent Urination
- Painful Urination
- Blood in Urine
- Kidney Infection
- Bed Wetting
- Inability to control urine
- Prostate trouble
- Decreased Libido

Health Concerns: Please list your top health concerns in order of priority.

1. _____
2. _____
3. _____

What type of treatment are you looking for? Please check all that apply.

- I am looking for the most minimal amount of care to “patch up” the symptoms of my condition.
- I am looking to resolve my symptoms, and then go on to address the cause of my condition.
- I am looking to resolve my symptoms, achieve optimal health, wellness, and disease prevention.

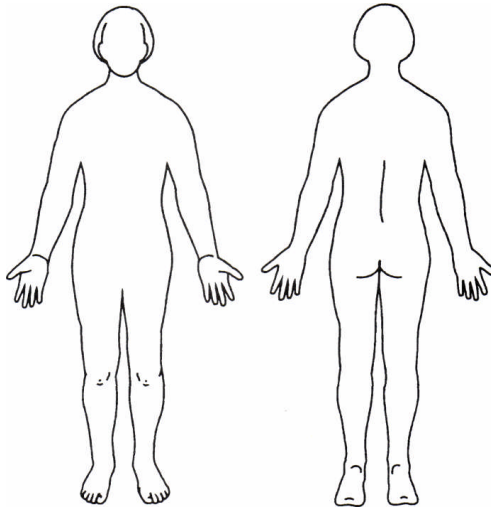
Please check all that apply:

- I have a health condition, I am concerned and I don’t know what it is.
- I have a medical condition and am receiving medical treatment and am unhappy with my results.
- I have a medical condition and wish to enhance my medical treatment.
- I have been to other doctors and/or chiropractors and continue to have health problems and wish to see if Dr. Roulo’s approach will help me.
- I am currently on medications/drugs and wish to get off them.
 - If yes, have you suggested this to the prescribing physician?
- I am currently on medications/drugs and wish to stay on them.
- I wish to discontinue medical treatment and am seeking an alternative method.
- I wish to be examined and evaluated from a holistic “total person” approach where my mental, structural, and physiologic systems are included in the treatment of my health or health conditions.

Primary Concern:

Location and severity of pain:

Indicate the location and type of pain on the drawing using the following symbols: Dull xxxxx Cramping /////
Sharp/stabbing ••••• Burning 00000 Tingling ///// Numbness +++++



On a scale of 1 to 10, with 1 representing minimal pain, and 10 representing unbearable pain, how would you rate your pain? _____

- Is your concern a result from: an auto accident? an injury at work? another accident?
- Has another doctor treated you for this condition? Y N When? _____
- Type of treatment _____
- Is this condition interfering with your: Work Sleep Daily Routine Recreation
 Other: _____
- What do you believe is wrong with you? _____

-Since your symptoms began, have you noticed a change in?

- Bowel function Yes No
- Bladder function Yes No
- Sexual function Yes No

Headaches:

If you are experiencing headaches, please fill out this section. Otherwise it can be skipped.

-What seems to bring on your headaches? Circle all that apply

- Physical Activity Excessive Stress Alcohol Caffeine Certain Foods
- Menstrual Period Other _____

What date did your headaches begin? / /

-How often do they occur? Time/week _____ Times/month _____ Other _____

-How long do they last? Less than an hour 1-3 hours Longer than 3 hours

 All waking hours Several hours to days Other _____

-Do you headaches wake you from sleep? No Sometimes Always

-Do any of the following occur with your headaches? Circle all that apply

- Nausea/vomiting Weakness Tremor Dizziness Vision problems
- Light/Sound sensitivity Other _____

-What makes your headaches better? Circle all that apply

- Nothing Rest Lying down Ice/Cold packs Massage Standing
- NSAIDS(aspirin, tyelonol) Medication Other _____

-When do you headaches usually start? Circle all that apply Constant/Anytime awake Midday

 Upon waking up in the morning During the evening

-What describes your pain? Circle all that apply

- Burning Dull Sharp Shooting Aching Throbbing
- Deep Vice-Like Other _____

-How would you rate your overall headache None 0 1 2 3 4 5 6 7 8 9 10