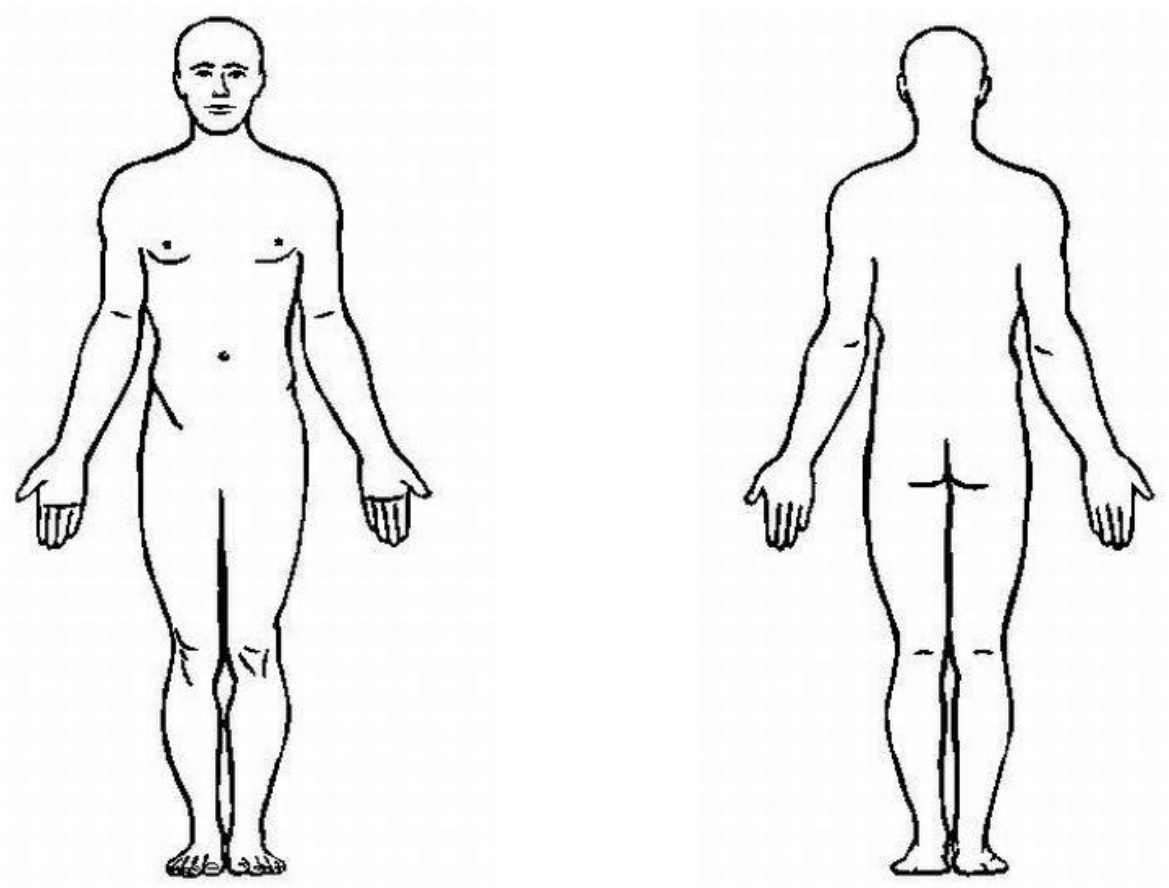
## Patient Pain Diagram

**Name (Print):**_____ **Date:**_____

**Using the symbols given below, mark the areas on the body where you feel the described sensations. Include ALL affected areas. It is NOT necessary to use all the symbols, only the ones which most affect you.**

| ACHING | NUMBNESS | PINS&NEEDLES | BURNING | STABBING | OTHER |
|---|---|---|---|---|---|
| □ | O | = | X | / | ● |

**FRONT** **BACK**



**PAIN IN ARM(S) COMPARED WITH NECK:** WORSE THAN SAME AS LESS THAN

**PAIN IN LEG(S) COMPARED WITH BACK:** WORSE THAN SAME AS LESS THAN

**CIRCLE THE INTENSITY OF PAIN: 0 1 2 3 4 5 6 7 8 9 10**

**NORMAL UNBEARABLE**

**I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT**

_____ _____

**SIGN** **DATE**

CAVANAUGH & RAIFORD CHIROPRACTIC
1908 Clearview Parkway Suite 103
Metairie, LA 70001

504-888-1115

# *(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent*

**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

## Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Cavanaugh & Raiford Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

## Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

## Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

## Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

| | |
|---|---|
| Patient or Legally Authorized Individual Signature | Date |
| Print Patient's Full Name | Time |
| Witness Signature | Date |

# NEW PATIENT REGISTRATION

## PERSONAL HISTORY

NAME: _____ DATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HM PHONE: _____ WK PHONE: _____ CELL: _____
BIRTHDATE: _____/_____/_____ AGE: _____ SEX: M OR F
HEIGHT: _____ WEIGHT: _____ TYPE OF WORK: _____
MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED
SS# _____-_____-_____
WHO CAN WE THANK FOR REFERRING YOU TO US TODAY? _____

## CURRENT HEALTH CONDITION

**MAJOR COMPLAINTS:**_____
_____
**WHEN DID THESE SYMPTOMS FIRST BEGIN?** _____
**YOUR COMPLAINT IS DUE TO:**
AUTO ACCIDENT WORK INJURY UNKNOWN CAUSES OTHER
**IF OTHER, PLEASE EXPLAIN:** _____
**DATE OF ACCIDENT / INJURY:** _____

**IS YOUR PAIN / PROBLEM:**
IMPROVING GETTING WORSE ABOUT THE SAME COMES & GOES

**CIRCLE ANY ACTIVITY THAT AGGRAVATES YOUR CONDITION:**
STANDING WALKING SITTING LYING BENDING
LIFTING TWISTING COUGHING SNEEZING

**WHEN IS YOUR PAIN / PROBLEM WORSE:**
MORNING NOON AFTERNOON NIGHT

**HAS IT DISTURBED YOUR SLEEP?** YES OR NO

**DO ANY POSITIONS RELIEVE THE PAIN?**
SITTING WALKING LYING

**WHAT DOES YOUR WORK CONSIST OF?**
SITTING STANDING LIGHT LABOR HEAVY LABOR

**IF DISABLED FROM WORK, PLEASE GIVE DATES:** _____

**HAVE YOU HAD THIS PAIN / PROBLEM BEFORE?** YES OR NO
**IF YES, WHEN?** _____

**HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION?** YES OR NO
**DOCTOR'S NAME &/OR FACILITY:**_____
**TYPE:** CHIROPRACTOR ORTHOPEDIC NEUROLOGIST PRIMARY CARE PHYSICIAN
**LAST TREATMENT / CONSULT DATE: _____ / _____ / _____**
**RECOMMENDED SURGERY?** YES OR NO
**DIAGNOSIS:** _____

**LIST ANY / ALL MEDICATIONS YOU ARE TAKING PRESENTLY:**
_____
_____

## PAST HEALTH HISTORY_____

**MAJOR ILLNESSES OR DISEASES:** _____
_____

**MAJOR ACCIDENTS OR FALLS:** _____

**MAJOR SURGERIES (PLEASE CIRCLE ANY THAT APPLY):**
APPENDIX TONSILS GALL BLADDER HERNIA HEART BACK NECK LEG ARM
FEMALE OTHER(PLEASE LIST): _____

**HOSPITALIZATION(S) OTHER THAN LISTED ABOVE:** _____
_____

**PREVIOUS CHIROPRACTIC CARE:** YES OR NO
**DOCTOR'S NAME &/OR CLINIC:** _____
**LAST VISIT: _____ / _____ / _____**

**HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION IN THE LAST YEAR?**
**CIRCLE ONE:** YES OR NO **IF YES, PLEASE EXPLAIN:** _____

**DOES ANYONE ELSE IN YOUR FAMILY SUFFER FROM THE SAME CONDITION?**
**CIRCLE ONE:** YES OR NO
**IF YES, PLEASE LIST CONDITION & RELATION:** _____
**LIST ANY DISEASES THAT RUN IN YOUR FAMILY:** _____

**DO YOU EXERCISE?** Y OR N **IF Y, INDICATE ONE:** MILD MODERATE STRENUOUS
**DO YOU SMOKE?** Y OR N **IF Y, HOW MANY PACKS / DAY?** _____
**DO YOU DRINK ALCOHOL?** Y OR N **IF Y, HOW MANY DRINKS / WEEK?** _____

**WHEN WAS YOUR LAST MENSTRUAL PERIOD?**
**FROM: ____ / ____ / ____ TO ____ / ____ / ____**
**ARE YOU PREGNANT?** YES OR NO **IF YES, DUE DATE: ____ / ____ / ____**
**IN CASE OF EMERGENCY, CONTACT(NAME):** _____ **RELATION:**_____
**HM PHONE:** _____ **WK PHONE:** _____ **CELL PHONE:** _____
**I CERTIFY THAT THIS INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:**

***PATIENT SIGNATURE:***_____ ***DATE:*** **____ / ____ / ____**

Cavanaugh & Raiford

# CHIROPRACTIC, INC.

## ATTENTION ALL PATIENTS

WE HAVE NOTICED A HUGE INCREASE IN PATIENTS MISSING APPOINTMENTS AND NOT CALLING TO CANCEL OR RESCHEDULE THEIR APPOINTMENT.

Because we allow a certain amount of time for each patient this means someone else could be seen in this time period.

**ALL APPOINTMENTS THAT ARE NOT CANCELLED OR RESCHEDULED 24 HOURS PRIOR TO THEIR APPOINTMENT TIME WILL BE *CHARGED $15.00*.**

_____ _____

Patient Signature Date