

Confidential Updated Patient Health History Questionnaire
Red Rock Chiropractic Center
Kyle J. Pankonin, D.C.

OFFICE USE ONLY	
<input type="checkbox"/> Demographic	<input type="checkbox"/> Labs
<input type="checkbox"/> Insurance	<input type="checkbox"/> Vitals
<input type="checkbox"/> Smoking	<input type="checkbox"/> CT/X-ray/MRI
<input type="checkbox"/> Medication	<input type="checkbox"/> Problem List
<input type="checkbox"/> Allergy	<input type="checkbox"/> Clinic
Height _____	
Weight _____	
BP _____	
Pulse _____	

Patient Title: (check v one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name	Nickname	Last Name	Middle Name	Suffix
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Address 1	Address 2
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City	State	Zip Code
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Primary Phone	Secondary Phone	Mobile Phone
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Home Email	Work Email
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Best Contact Method: (check v one) Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Verification Question: (check v one, then give the answer to that question below)

What is the name of your favorite pet? What city were you born in? What high school did you attend?
 What is your favorite movie? What is your mother's maiden name? What street did you grow upon?
 What was the make of your first car? What is your anniversary? What is your favorite color?

Verification Answer (MUST be at least 6 characters): _____

What is your email address that you prefer to have communication sent to you from this office (for health records, etc.)?
 Home email Work email Other _____

Date of Birth:	Age:	Gender (check v one):	Marital Status (check v one):
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unspcfd	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other

Employment Status: (check v one) Employed FT Student PT Student Other Retired Self-Employed

Social Security Number: _____

Race: (check v one) White Black/African American Hispanic American Indian/Alaskan Native Asian
 Asian Indian Chinese Filipino Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
 Guamanian or Chamorro Samoan Other I choose not to specify

Multi-Racial: (check v one) Yes No Unknown I choose not to specify

Ethnicity: (check v one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language: (check v one) English Spanish American Sign Language Chinese French German
 Tagalog Vietnamese Italian Korean Russian Polish Arabic Portuguese Japanese French
Creole Greek Hindi Persian Urdu Gujarati Armenian Other I choose not to specify

Insurance Information:

Primary Insurance: _____ Policyholder Name: _____
Policyholder Birth Date: _____ Your Relationship to Subscriber: _____
Secondary Insurance: _____ Policyholder Name: _____
Policyholder Birth Date: _____ Your Relationship to Subscriber: _____

Insurance Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Red Rock Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____	Date _____
I request that payment of authorized Medicare benefits be made of my behalf to Red Rock Chiropractic Center for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.	
Responsible Party Signature _____	Date _____

Do you currently smoke tobacco of any kind?: (check **V one)** Yes Never been a smoker Former smoker

If yes, how often do you smoke? Current everyday smoker Current somedays smoker

If yes, how much do you smoke? Less than 1 pack a day 1 pack a day More than 1 pack a day

If yes, what is your level of interest in quitting smoking?

0 1 2 3 4 5 6 7 8 9 10 N/A

Current Medications: Please list current medications including dosage, if known.

I am currently not taking any medications.

Medication Name	Dosage & Frequency	Medication Name	Dosage & Frequency
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Medication Allergies: Please list any known allergies that you have to any medications.

I have no known medication allergies.

1.	3.
2.	4.

Main Health Problems: Briefly list the name of your problem(s)/conditions, regardless of whether you are treating them with chiropractic or not. _____

Has any doctor diagnosed you with Hypertension (high blood pressure) presently? Yes No

If yes, what kind (primary or secondary)? _____

Has any doctor diagnosed you with Diabetes presently? Yes No

If yes, what kind? Type I (Juvenile Onset) Type 2 (Adult Onset)

If yes, was your blood lab-work test for hemoglobin A1c>9.0% Yes No Not sure

Has any doctor diagnosed you with any type of significant health syndrome presently? Yes No Not sure

If yes, what kind? _____

Have you had an x-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

Informed Consent to be Treated

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, strokes, and soreness. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Patient or Legal Guardian Signature

Date

Consent to Electronic Communication

I acknowledge the privacy risks associated with using Electronic communications and authorize Red Rock Chiropractic Center staff and/or doctor to communicate with me or any minor dependent/ward for purpose of medical advice, education, clinical record summaries, full medical records, and/or appointment reminders. I understand that my e-mail address will not be given to anyone outside of this clinic for any reason and that this will be for medical purposes only.

Patient or Legal Guardian Signature

Date

HIPAA Privacy Act

I have received RRCC, notice of HIPAA Privacy Act. I authorize RRCC to release to my insurance company, health plan, HMO, no-fault carrier, and/or workers' compensation carrier, any information including my complete health record needed to determine benefits for services provided by or on behalf of RRCC. I understand and agree that I am financially responsible to RRCC, for any and all charges not covered by insurance for myself, spouse, and dependents.

Patient or Legal Guardian Signature

Date