Marker Chiropractic Associates
204 E. Superior Street, Suite 3
Sandpoint, ID 83864
(208)946-3990
www.markerchiropractic.com
drmarker@msn.com

Chiropractic Registration and Health History Form

Patient Information

Name_____ Date_____

Email _____ *Your email will NOT be shared with any 3rd parties, and is used for general office reminders and information.*

Who may we thank for referring you to our practice? _____

Address _____ City _____ State _____ Zip _____

Billing Address _____ City _____ State ____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____
I authorize text message reminders and payment receipts ***YES/ NO***

Age _____ Birth Date _____ Social Security # _____

Occupation _____ Employer _____

Marital Status _____ Spouse's Name _____

Emergency Contact _____ Relationship _____ Phone # _____

Responsible Party Information

Who is responsible for this account? _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Social Security # _____

I understand that I am financially responsible for all charges. Payments are due at time of services.

Family History

Family Member	Present and past health conditions (example: heart disease, cancer, diabetes, arthritis, etc)
Mother	
Father	
Grandparent Paternal	
Grandparent Maternal	
Brother	
Sister	

Patient Name: _____

MEDICAL HISTORY (all patients fill out)

1. When was your last physical exam? _____ Who performed it? _____
   □ Do not recall when I had my last physical exam
   Have you been treated previously by a Chiropractor? If so List the Doctor's Name and date last seen.
   _____

2. Have you had any previous accidents/traumas/falls? **Yes/ No/ Do not recall** Date: _____
   If yes, do you currently experience similar or different conditions? **Similar/Different**
   Explain any changes in intensity/frequency/duration of the pain you feel currently:_____
   _____

3. Explain any previous hospitalizations: _____
   □ Do not recall any previous hospitalizations

4. Have you had any surgeries? **Yes/ No/ Do not recall**
   What type(s) and date(s)? _____

5. Have you had any previous work-related injuries? **Yes/ No/ Do not recall** Date: _____
   If yes, do you currently experience similar or different conditions? **Similar/Different**
   Explain any changes in intensity/frequency/duration of the pain you feel currently: _____
   _____

6. List any medications you are currently taking: □ Not applicable
   □ Insulin □ Cortisone □ Nerve Pills □ Antidepressants
   □ Blood pressure medication □ Vitamins/supplements _____
   □ Aspirin--How often? _____ □ Pain killer/muscle relaxants
   List names of medications and how often taken: _____
   _____

7. Please list any allergies: □ none known □ dairy products □ eggs □ mold □ peanuts
   □ perfume □ pet dander □ poison ivy □ pollen □ smoke □ strawberries
   □ wheat □ other—Please explain: _____

8. Please check all that apply. □ use alcohol #____per day □ use tobacco # ____per day
   □ use caffeine #____per day □ wear orthotics
   □ exercise regularly □ have good sleep habits □ have a well-balanced diet
   □ eat low salt/fat diet □ experiencing stress at home/work
   Include any explanation you feel necessary:_____

Have you ever suffered from:

Allergies □	Anemia □	Arteriosclerosis □	Arthritis □	Back Pain □
Breast Lump □	Bronchitis □	Bruise Easy □	Cancer □	Chest Pain □
Cold Extremities □	Constipation □	Cramps □	Depression □	Diabetes □
Digestion Problems□	Dizziness □	Fatigue □	Headache □	High Blood Pressure □
Insomnia □	Kidney Problems □	Loss of Balance □	Lumps in Breasts □	Neck Pain □
Nervousness □	Pacemaker □	Polio □	HIV □	Prostate Problems □
Sciatica □	Shortness of Breath □	Sinus Infection □	Stroke □	Swelling □
Thyroid Cond. □	Tuberculosis □	Ulcers □	Varicose Veins □	Other:

Patient Name: _____

CHIEF COMPLAINT (all clients fill out)

Note: Ranking 1-10 key: 1-4=mild, uncomfortable; 5-7= distressing; 8-10= intense and unbearable

A. Check all that apply. Do you experience:

□ **Neck pain-** Where: □ shoots into upper back on right side □ shoots into upper back on left side
□ upper/lower □ more right sided □ more left sided □other:_____
Intensity: (rank 1-10):_____ Comments:_____

□ **Headaches-** Where:□ whole head □ forehead □ back of head □ behind eye □ temple □ right side
□ left side □ other:_____
Intensity: (rank 1-10):_____ Comments:_____

□ **Mid back pain-** Where: □ whole mid back □ more right sided □ more left sided
□ shooting around chest □ other:_____
Intensity: (rank 1-10):_____ Comments:_____

□ **Low back pain-** Where: □ whole low back □ more right sided □ more left sided
□ shoots into right/left leg □ other:_____
Intensity: (rank 1-10):_____Comments:_____

□ **Other:**_____- Where specifically:_____
Intensity: (rank 1-10):_____Comments:_____

B. Do you have bowel or bladder problems: **Yes/ No** _____

C. Are you pregnant? Yes/No If yes, due date:_____

D. Do you feel pain in the: □ right arm □ left arm □ right leg □ left leg □ankles □ knee □ hips
□ not applicable

E. Do you feel: □ numbness or tingling in the legs and/or feet □ loss of balance
□ numbness or tingling in the arms □ not applicable

F. Describe any additional information regarding your condition:
_____

G. Possible jaw pain symptoms. Check all that apply:
□ ear pain, ache, itch, sharp pain □ ringing in the ear □ dizziness □ teeth problems
□ face numbness □ grind teeth at night □ jaw joint pain or clicking □ ear fullness, plugged
□ other experienced TMJ related symptoms not listed: _____
□ not applicable

H. Possible foot/leg related symptoms. Check all that apply:
□ knee pain □ foot pain □ foot numbness at bottom of foot
□ hip pain □ low back pain □ pelvic pain □ leg pain
□ other experienced foot/leg pain not listed_____ □ not applicable

I. Possible brain and brainstem related symptoms. Check all that apply:
□ problems w/ long or short term memory □concentration problems □aggravation by noise
□ anxiety □ depression □ irritability □ sleep problems □ sex problems □fatigue
□ change in smell or taste □ other-please explain: _____ □ not applicable

Patient Name: _____

J. How long/regularly do you experience the pain?
☐ all the time ☐ during the day ☐ during the night ☐ more than 6 hours ☐ less than 1 hour
☐ in intervals--How long each time? _____
☐ other--Please explain: _____

K. What makes the symptoms better?
☐ aspirin ☐ movement—In what direction: _____
☐ heat ☐ ice ☐ massage ☐ muscle relaxants ☐ rest
☐ stretching ☐ bed rest ☐ elevation ☐ nothing
☐ other--Please explain: _____

L. Describe any activities that make symptoms worse:
_____

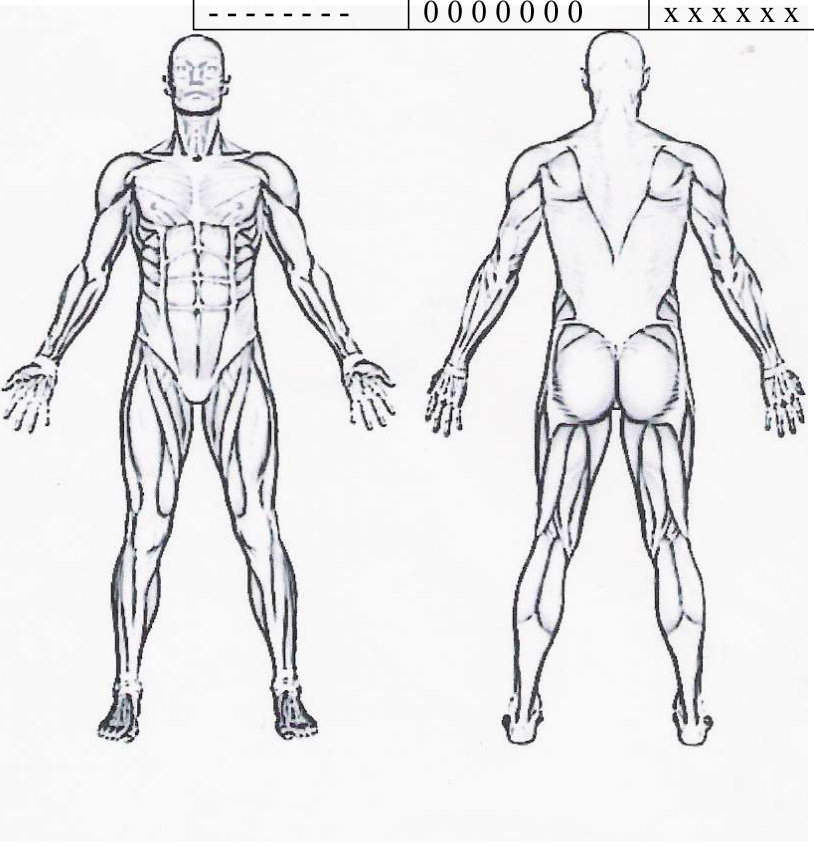
M. How and when did the pain begin: _____

N. Did the accident/injury/incidence of pain occur more than two weeks ago? **Yes/No**
If yes, please explain why you did not come in before two weeks:_____
_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - -	0 0 0 0 0 0 0	x x x x x x	* * * * * *	/ / / / / / /
- - - - - - - -	0 0 0 0 0 0 0	x x x x x x	* * * * * *	/ / / / / / /
- - - - - - - -	0 0 0 0 0 0 0	x x x x x x	* * * * * *	/ / / / / / /



Pain Chart
Please mark the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my Discomfort as follows
(_____)
0 10
No pain Severe pain

Mid Back Pain
On a scale of zero to 10, I rate my Discomfort as follows
(_____)
0 10
No pain Severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my Discomfort as follows
(_____)
0 10
No pain Severe pain

Patient Name: _____

CONSENT TO TREAT & FINANCIAL AGREEMENT (*Please read and sign*)

I hereby authorize the Doctor to treat my condition/the condition of my child or legal ward (***please circle***) as he deems appropriate.

The primary treatment used by the Doctor is spinal manipulative therapy; this will be used for treatment. Hands or a mechanical instrument may be used upon my body in such a way as to move my joints. That may cause an audible "pop" or "click," and I may feel a sense of movement. Other treatment options include: physical therapies, self-administered therapies, over-the-counter analgesics and rest. If one of these "other treatment" options is chosen, I am aware that there are risks and benefits of such options and that I may want to discuss these with my primary care physician.

I understand that fees are payable at time of services unless other arrangements are made in advance. I am responsible for my full co-payment and/or deductible on each visit.

I understand that records are the property of the clinic; however, The Board of Chiropractic Medicine Rule 64B-17.0055, Administrative Code, authorizes chiropractic physicians $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I fully understand that I am directly and fully responsible to Marker Chiropractic for all bills incurred for services rendered to me and that this agreement is made solely for the Marker Chiropractic's additional protection and in consideration contingent of any settlement, judgment or verdict by which I may eventually recover. I authorize this office to furnish requested information to my insurer or attorney with a properly signed release. If collection or legal actions become necessary in payment of services rendered by Marker Chiropractic, I understand I will be responsible for all fees incurred by Marker Chiropractic.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Marker and have had my questions answered to my satisfaction. By signing below, I state I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

I have also read, understand, and agree to the financial agreement stated above.

_____ _____

Date Patient Signature, or Parent/Legal Guardian for patient under 18 years

OUR CANCELATION POLICY & OFFICE NOTICE

An appointment is a commitment by yourself and the doctor to set aside time to treat you. Therefore, we request that our patients notify us at least 24 hours in advance when canceling or rescheduling an appointment so that we may make the appointment available to those who need it.

We reserve the right to charge a Missed Appointment Fee of $25.00 to those patients who miss their appointment without notifying us, or who cancel/ reschedule an appointment with less than 24-hour notice. This fee is due within 14 days of invoice.

So as not to inconvenience those who arrive at their appointed time, late comers may receive shortened treatment at the regular treatment fee. Those who arrive for their scheduled appointments will be served first.

Also, we are not responsible for lost or stolen personal items. We are not responsible for your children or any children that might be with you during your visit. We are not responsible for any injuries that occur at home from doing exercises the doctor gives you.

We value your business and strive to ensure that we are always available to you when you need us. Thank you.

I understand and agree to the above:

_____ _____

Date Patient Signature, or Parent/Legal Guardian for patient under 18 years

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (your name), acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of MARKER CHIROPRACTIC ASSOCIATES, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created , received or maintained by the Practice.

_____ _____

Date Patient Signature, or Parent/Legal Guardian for patient under 18 years

Patient Name: _____

MARKER CHIROPRACTIC ASSOCIATES
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of Our Privacy Practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of 09/01/2007, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

A. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

B. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

I authorize Marker Chiropractic Associates to disclose information regarding my health information to the following individuals.

_____

_____

C. MARKETING: We will not use your health information for marketing communications without your written authorization.

D. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

E. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary at avert a serious threat to your health or safety or the health or safety of others.

F. LAW ENFORCEMENT / NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

Patient Name: _____

G. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, postcards, emails or letters).

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we may charge you $1.00 for the first 25 pages and $0.25 for each page thereafter and reasonable postage if you want the copies mailed to you. X-rays taken within our office are the property of the office. If a copy of the x-ray is requested the cost of the copy to be generated and all reasonable fees incurred are the responsibility of the patient. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before **April 14, 2003.** If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in print form as well.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decision we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services.
Please direct any of your questions or complaints to:

CONTACT:	Dr. James Marker – Doctor	Marker Chiropractic, LLC.
PHONE:	(208)946-3990	drmarker@msn.com