PATIENT'S HISTORY FORM

PLEASE PRINT file: Hxform

Last Name_____First Name_____MI_____
Birth Date_____Social Security No._____
Address_____Apt#____City_____ State_____ Zip_____
Driver's License #_____Phone Home ( )_____ Work ( ) _____
Who referred you?_____ Cell Phone( )_____
E-mail address_____ Date_____
occupation_____

Do you NOW have any of the following conditions?

O Congestive heart failure?
O Chronic lung disease (including bronchitis or emphysema)?
O Blindness or trouble seeing, even when wearing glasses?
O Deafness or trouble hearing?
O Sugar diabetes (diabetes mellitus) Type I?
O Sugar diabetes (diabetes mellitus) II adult onset?
O Asthma?
O Ulcer or gastrointestinal bleeding (not counting hemorrhoids)?
O Arthritis or rheumatism?
O Sciatica or chronic back problem
O Hypertension or high blood pressure
O Angina?
O Heart attack or myocardial infarction
O Stroke?
O Kidney disease?
O Cancer?
O Depression?
O Currently pregnant #weeks_____
O Family history of serious illnesses. List_____
0 other_____

O Do not smoke - *If you smoke cigarettes, how many do you smoke in a average day?*
O Less than ½ pack *O* ½ to 1 pack *O* 1 to 2 packs *O* More than 2 packs

O Do not drink - *If you drink alcohol, about how many drinks in a average day?*
O < 1 *O* No more than 1 *O* 1 or 2 drinks *O* 3 to 5 drinks *O* 6 to 8 drinks *O* More than 8 drinks

O Do you drink coffee - *If you drink coffee, about how many cups on a average day?*
O <1 O No more than 1 O 1 or 2 cups O 3 to 5 cups O 6 to 8 cups O More than 8 cups

Current medications taking (use separate sheet if needed) _____
_____

Nutritional supplements that you are taking_____

Overall health (circle one) excellent/good/fair/other:_____

List any surgery's_____

Previous treatment for this current complaint_____

Please complete the next page

How would you describe your chief complaint at this time?

_____

_____

When did it start? _____ Date_____

What is your history with this injury?
O Sudden Trauma *O* Reoccurrence *O* Repetitive trauma

Is your pain from a motor vehicle accident/ work injury/personal injury ?(circle answer)

What makes the pain worse?_____

_____

What makes the pain better?_____

_____

How would you describe your pain?_____

_____

Where is your pain located?_____

_____

At what time of the day or week is your pain worst?_____

The pain is....
O Intermittent *O* It usually lasts for_____ *O* minute(s) *O* hour(s) *O* day(s)
O week(s) *O* Constant

How long have you been having pain?	How many times have you had this problem in the past?	When did you first have these or similar symptoms?
O 1 week or less	*O* Never	*O* Never
O 1-6 weeks	*O* 1-3 episodes	*O* <6 months ago
O <6 weeks <3 months	*O* 4 or more episodes	*O* 6 months - 1 years ago
O 3 months - 1 year		*O* More than 1 year ago
O Over 1 year		

Marital Status: S M D W Name of Spouse_____
Describe health of spouse:_____ Number of children if any_____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	_____	M/F _____
_____	_____	_____	M/F _____
_____	_____	_____	M/F _____

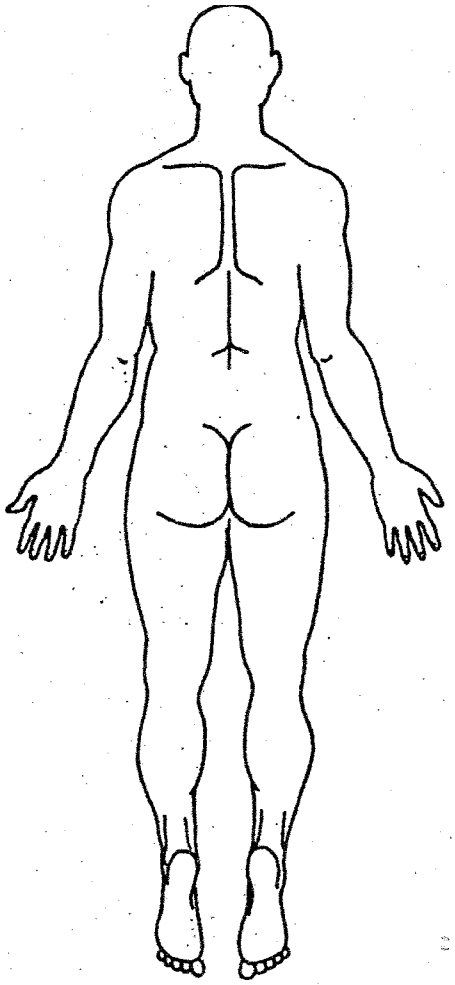
What can we do to make you happier?_____

Office Use Only:
Height:_____ Weight:_____ Age:_____ Body Fat %:_____ BMI Index:_____
B/P: Sitting_____ Standing_____

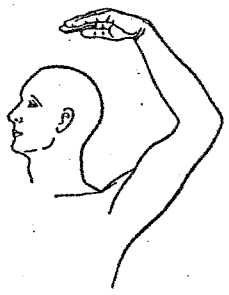
ANALOGUE PAIN SCALE

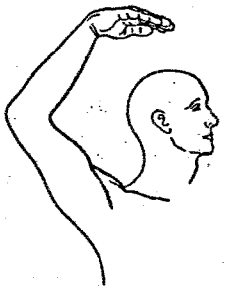
Name _____ Date _____

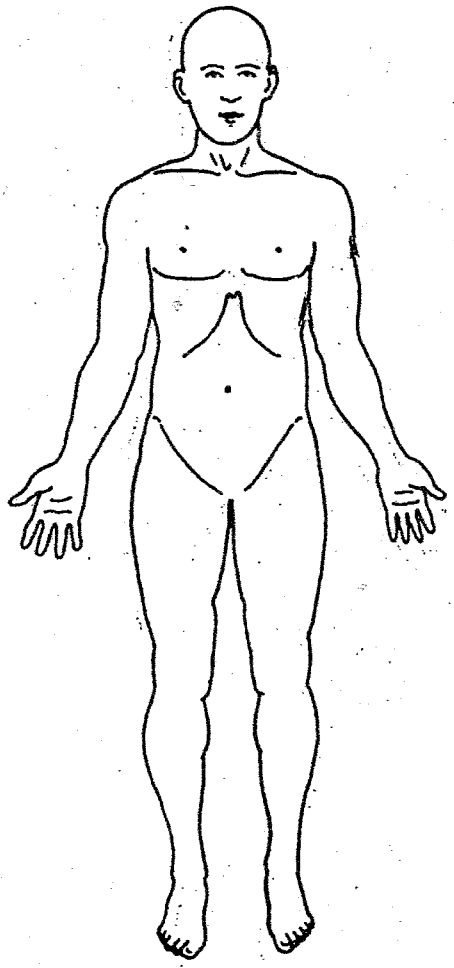
Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.



Sharp and Stabbing = ++++
Dull and Achy = VVVV
Pins and Needles = 0000
Numbness = ////







Please check the appropriate # to describe your present pain level:
With 0 being Normal/or no pain; and 10 being very severe pain.

C = CONSTANT
I = INTERMITTENT

Area of pain	Normal	Mildly in pain	Moderate pain	Severe pain		
Neck	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Middle back	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Lower back	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Hip(s) Lt Rt	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Shoulder(s) Lt Rt	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Arm(s) Lt Rt	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Legs Lt Rt	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Heachaches	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Other:	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Other:	☐ 1	2 3 4	5 6 7	8 9 10	C	I
Other:	☐ 1	2 3 4	5 6 7	8 9 10	C	I

Alward Wellness Center 3339 El Camino Ave.Sacramento, CA 95821

Notice of Health Information Practices

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

PLEASE REVIEW CAREFULLY.

Introduction

At Alward Wellness Center, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, how and when we use or disclose the information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit our office, a record of your visit is made. Typically, this record contains your symptoms, examination and tests results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A source of data for medical research.
- A source of data for our planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of our office, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record (there will be a .25 cent charge for every page copied).
- Amend your health record.
- Obtain an accounting of disclosures of your health information.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities Our office is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.

We will not use or disclose your health information without your authorization, except as describe in this notice. We will also discontinue to use or disclose your health information after we receive a written revocation of the authorization according to the procedures included in the authorization.

For more Information or to report a Problem

If you have questions and would like additional information, you may contact our Privacy officer, Patrice Alward at 916-485-2225

_____ _____

Patient Signature Date

_____

Witness Signature

Fl:nhip