Alternative Health Care Center of the Black Hills

GENERAL INFORMATION

(If more space is needed when filling in certain sections, please feel free to provide separate sheet)

Name: First _____ (Preferred) _____ Middle _____ Last _____

Date: ____/____/____ Date of Birth: ____/____/____ Age: _____ Gender: ☐ Male ☐ Female

SSN: _____ Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership ☐ Widow

Spouse/Significant Other's Name: _____

Primary Address: _____ Apt. No.:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Do you work? Where? _____

☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Homemaker ☐ Unemployed

Your job is: ☐ Difficult ☐ Enjoyable ☐ Stressful ☐ Relaxed

Your job requires: ☐ Heavy Lifting ☐ Sitting ☐ Standing ☐ Walking

Best Phone and Times to Reach You: _____

Email: _____ Fax: _____

Emergency Contact: Name: _____ Phone: _____

Relationship to you: _____ Address: _____

City: _____ State: _____ Zip: _____

Your Genetic Background: ☐ African ☐ Asian ☐ European ☐ Ashkenazi ☐ Native American

☐ Middle Eastern ☐ Mediterranean ☐ Other _____

Highest Education Level: ☐ High School or Equivalent ☐ Graduate ☐ Post-Graduate

Job Title: _____

Nature of Business: _____

Primary Pharmacy: Name _____ Phone _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Fax: _____

Whom may we thank for referring you? _____

How did you hear about us? ☐ Website ☐ Facebook ☐ Magazine/Ad ☐ Radio ☐ Other _____

INSURANCE INFORMATION

We file a claim to your insurance company as a courtesy to you. Only one visit per day will be submitted; however, you are responsible for any co–payment and deductible amounts at the time of service, unless previously arranged. You will also be responsible for any services that are not covered by your insurance company, unless previously arranged. Payment options and arrangements may be discussed at any time; however, it is best to let us know in advance so we can get account information accessible.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with: Name of Insurance Company(ies): _____ and assign directly to Alternative Health Care 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 authorize the use of my signature on all insurance submissions. The above–named facility may use my health care information and may disclose such information to the above–named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance for the purpose of benefits payable for related services.

Signature of Patient, Parent, Guardian, or Personal Representative _____

Please print name of Patient, Parent, Guardian, or Personal Representative _____

Date ____/____/____ Relationship to Patient _____

PAYMENT INFORMATION

We offer a few different methods of payment to make your journey to wellness as convenient as possible. We discuss these payment options with you at your Report of Findings visit. We accept cash, check, credit and debit.

HEALTH CONCERNS & GOALS

Please list current and/or ongoing areas of concern you would like to address in order of priority.

Health Concern or Goal #1 (Please describe as many details as you can) _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: ☐ Better ☐ Worse ☐ About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: _____

_____

What makes it better? _____

What makes it worse? _____

Rate your pain right now on a scale of 0–10, with 0 being no pain at all and 10 being hospital–worthy: _____

What would you rate your pain at its best? _____ What would you rate your pain at its worst? _____

If pain is associated with your condition, please check all that apply: *(Type of pain)*

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain radiate down your leg(s) or arm(s)? _____

Have you experienced this before? _____ How often do you experience this condition? _____

Is it constant or does it come and go? _____

Does it prevent you from doing certain activities or limit your daily living routine such as:

☐ Working ☐ Lifting ☐ Personal Care ☐ Sitting ☐ Standing ☐ Sleeping ☐ Walking

☐ Social Life ☐ Exercising ☐ traveling ☐ Other _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #2 (Please describe as many details as you can) _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: ☐ Better ☐ Worse ☐ About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: _____

_____

What makes it better? _____

What makes it worse? _____

Rate your pain right now on a scale of 0–10, with 0 being no pain at all and 10 being hospital–worthy: _____

What would you rate your pain at its best? _____ What would you rate your pain at its worst? _____

If pain is associated with your condition, please check all that apply: *(Type of pain)*

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain radiate down your leg(s) or arm(s)? _____

Have you experienced this before? _____ How often do you experience this condition? _____

Is it constant or does it come and go? _____

Does it prevent you from doing certain activities or limit your daily living routine such as:

☐ Working ☐ Lifting ☐ Personal Care ☐ Sitting ☐ Standing ☐ Sleeping ☐ Walking

☐ Social Life ☐ Exercising ☐ traveling ☐ Other _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #3 (Please describe as many details as you can) _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: ☐ Better ☐ Worse ☐ About the same

What treatments have you tried? Please list everything - home remedies to medical interventions: _____

_____

What makes it better? _____

What makes it worse? _____

Rate your pain right now on a scale of 0–10, with 0 being no pain at all and 10 being hospital–worthy: _____

What would you rate your pain at its best? _____ What would you rate your pain at its worst? _____

If pain is associated with your condition, please check all that apply: *(Type of pain)*

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Does the pain radiate down your leg(s) or arm(s)? _____

Have you experienced this before? _____ How often do you experience this condition? _____

Is it constant or does it come and go? _____

Does it prevent you from doing certain activities or limit your daily living routine such as:

☐ Working ☐ Lifting ☐ Personal Care ☐ Sitting ☐ Standing ☐ Sleeping ☐ Walking

☐ Social Life ☐ Exercising ☐ traveling ☐ Other _____

Anything else you feel is important about this condition? _____

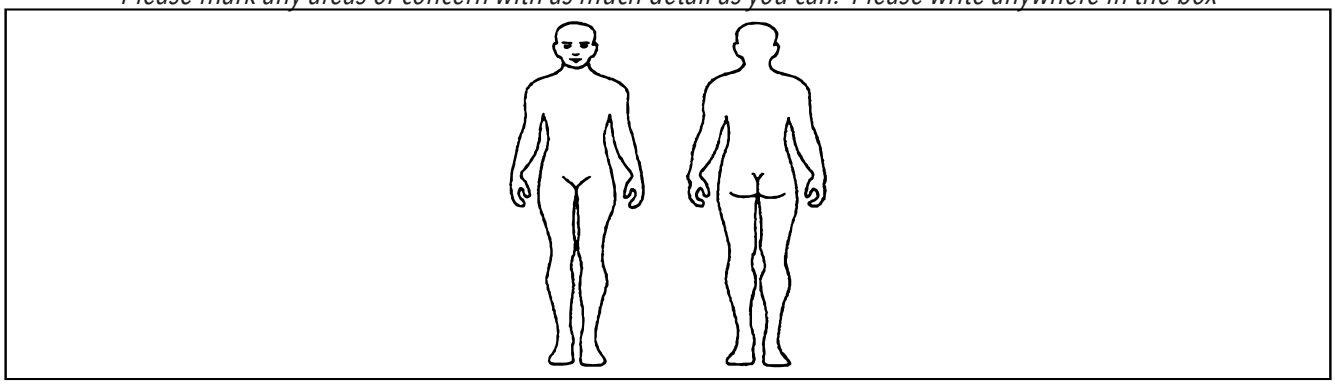
In general, what do you hope to achieve with your visits here? _____

_____

_____

When was the last time you felt exceptionally well? _____

Please mark any areas of concern with as much detail as you can. Please write anywhere in the box



MEDICAL HISTORY

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

☐ Doctor of Chiropractic *Name:* _____ *City:* _____

Treatment Focus: _____

☐ M.D. / D.O. *Name:* _____ *City:* _____

Treatment Focus: _____

☐ Physical Therapist *Name:* _____ *City:* _____

Treatment Focus: _____

☐ Acupuncture *Name:* _____ *City:* _____

Treatment Focus: _____

☐ Other: _____ *Name:* _____ *City:* _____

Treatment Focus: _____

Hospitalizations *(car accidents, horseback riding accidents, illnesses, surgeries, etc.)* ☐ None

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Allergies

Medication/Supplement/Food:	*Reaction:*

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide Month/Year of onset.* ☐ *Past Condition* ☐ *Ongoing Condition*

Gastrointestinal

- ☐ ☐ Irritable Bowel Syndrome ____ / ____
- ☐ ☐ Inflammatory Bowel Disease ____ / ____
- ☐ ☐ Crohn's ____ / ____
- ☐ ☐ Ulcerative Colitis ____ / ____
- ☐ ☐ Gastritis or Peptic Ulcer Disease ____ / ____
- ☐ ☐ GERD *(reflux)* ____ / ____
- ☐ ☐ Celiac Disease ____ / ____
- ☐ ☐ Hemorrhoids ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Cardiovascular

- ☐ ☐ Heart Attack ____ / ____
- ☐ ☐ Other Heart Disease ____ / ____
- ☐ ☐ Stroke ____ / ____
- ☐ ☐ Elevated Cholesterol ____ / ____
- ☐ ☐ Arrhythmia *(irregular heart rate)* ____ / ____
- ☐ ☐ Hypertension *(high blood pressure)* ____ / ____
- ☐ ☐ Rheumatic Fever ____ / ____
- ☐ ☐ Mitral Valve Fever ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Cancer

- ☐ ☐ Lung Cancer ____ / ____
- ☐ ☐ Breast Cancer ____ / ____
- ☐ ☐ Colon Cancer ____ / ____
- ☐ ☐ Ovarian Cancer ____ / ____
- ☐ ☐ Prostate Cancer ____ / ____
- ☐ ☐ Skin Cancer ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Genital & Urinary Systems

- ☐ ☐ Kidney Stones ____ / ____
- ☐ ☐ Gout ____ / ____
- ☐ ☐ Interstitial Cystitis ____ / ____
- ☐ ☐ Frequent Urinary Tract Infections ____ / ____
- ☐ ☐ Frequent Yeast Infection ____ / ____
- ☐ ☐ Erectile or Sexual Dysfunction ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Metabolic/Endocrine

- ☐ ☐ Type 1 Diabetes ____ / ____
- ☐ ☐ Type 2 Diabetes ____ / ____
- ☐ ☐ Hypoglycemia ____ / ____
- ☐ ☐ Metabolic Syndrome ____ / ____ *(Insulin Resistance/Pre-Diabetes)*
- ☐ ☐ Hypothyroidism *(low thyroid)* ____ / ____
- ☐ ☐ Hyperthyroidism *(overactive thyroid)* ____ / ____
- ☐ ☐ Endocrine Problems ____ / ____
- ☐ ☐ Polycystic Ovarian Syndrome *(PCOS)* ____ / ____
- ☐ ☐ Infertility ____ / ____
- ☐ ☐ Weight Gain ____ / ____
- ☐ ☐ Weight Loss ____ / ____
- ☐ ☐ Frequent Weight Fluctuations ____ / ____
- ☐ ☐ Bulimia ____ / ____
- ☐ ☐ Anorexia ____ / ____
- ☐ ☐ Binge Eating Disorder ____ / ____
- ☐ ☐ Night Eating Disorder ____ / ____
- ☐ ☐ Eating Disorder *(non-specific)* ____ / ____
- ☐ ☐ Other: _____ ____ / ____

DISEASES/DIAGNOSIS/CONDITIONS *(continued...)*

Musculoskeletal/Pain

- ☐ ☐ Osteoarthritis ____ / ____
- ☐ ☐ Fibromyalgia ____ / ____
- ☐ ☐ Chronic Pain ____ / ____
- ☐ ☐ Tendonitis ____ / ____
- ☐ ☐ Tension Headaches ____ / ____
- ☐ ☐ TMJ Problems ____ / ____
- ☐ ☐ Foot Cramps ____ / ____
- ☐ ☐ Joint Deformity ____ / ____
- ☐ ☐ Joint Pain ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Inflammatory/Autoimmune

- ☐ ☐ Chronic Fatigue Syndrome ____ / ____
- ☐ ☐ Autoimmune Disease ____ / ____
- ☐ ☐ Rheumatoid Arthritis ____ / ____
- ☐ ☐ Lupus SLE ____ / ____
- ☐ ☐ Immune Deficiency Disease ____ / ____
- ☐ ☐ Herpes–Genital ____ / ____
- ☐ ☐ Cold Sores ____ / ____
- ☐ ☐ Severe Infectious Disease ____ / ____
- ☐ ☐ Poor Immune Function *(frequent infections)* ____ / ____
- ☐ ☐ Food Allergies ____ / ____
- ☐ ☐ Environmental Allergies ____ / ____
- ☐ ☐ Multiple Chemical Sensitivities ____ / ____
- ☐ ☐ Latex Allergy ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Respiratory Diseases

- ☐ ☐ Asthma ____ / ____
- ☐ ☐ Chronic Sinusitis ____ / ____
- ☐ ☐ Bronchitis ____ / ____
- ☐ ☐ Emphysema ____ / ____
- ☐ ☐ Pneumonia ____ / ____
- ☐ ☐ Tuberculosis ____ / ____
- ☐ ☐ Sleep Apnea ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Head, Eyes & Ears

- ☐ ☐ Conjunctivitis ____ / ____
- ☐ ☐ Distorted Sense of Smell ____ / ____
- ☐ ☐ Distorted Taste ____ / ____
- ☐ ☐ Ear Fullness ____ / ____
- ☐ ☐ Ear Pain ____ / ____
- ☐ ☐ Hearing Loss ____ / ____
- ☐ ☐ Hearing Problems ____ / ____
- ☐ ☐ Headache ____ / ____
- ☐ ☐ Migraine ____ / ____
- ☐ ☐ Sensitivity to Loud Noises ____ / ____
- ☐ ☐ Vision Problems *(other than glasses)* ____ / ____
- ☐ ☐ Macular Degeneration ____ / ____
- ☐ ☐ Vitreous Detachment ____ / ____
- ☐ ☐ Retinal Detachment ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Nails

- ☐ ☐ Bitten ____ / ____
- ☐ ☐ Brittle ____ / ____
- ☐ ☐ Curve Up ____ / ____
- ☐ ☐ Frayed ____ / ____
- ☐ ☐ Fungus–Fingers ____ / ____
- ☐ ☐ Fungus–Toes ____ / ____
- ☐ ☐ Pitting ____ / ____
- ☐ ☐ Ragged Cuticles ____ / ____
- ☐ ☐ Ridges ____ / ____
- ☐ ☐ Soft ____ / ____
- ☐ ☐ Thickening of Finger Nails ____ / ____
- ☐ ☐ Thickening of Toenails ____ / ____
- ☐ ☐ White Spots/Lines ____ / ____
- ☐ ☐ Other: _____ ____ / ____

Skin Diseases

- ☐ ☐ Acne on Back ____ / ____
- ☐ ☐ Acne on Chest ____ / ____
- ☐ ☐ Acne on Face ____ / ____
- ☐ ☐ Acne on Shoulders ____ / ____
- ☐ ☐ Athlete's Foot ____ / ____
- ☐ ☐ Bumps on Back of Upper Arms ____ / ____
- ☐ ☐ Cellulite ____ / ____
- ☐ ☐ Dark Circles Under Eyes ____ / ____
- ☐ ☐ Ears Get Red ____ / ____
- ☐ ☐ Easy Bruising ____ / ____
- ☐ ☐ Lack of Sweating ____ / ____
- ☐ ☐ Hives ____ / ____
- ☐ ☐ Jock Itch ____ / ____
- ☐ ☐ Lackluster Skin ____ / ____
- ☐ ☐ Moles with Color/Size Change ____ / ____
- ☐ ☐ Oily Skin ____ / ____
- ☐ ☐ Pale Skin ____ / ____
- ☐ ☐ Patchy Dullness ____ / ____
- ☐ ☐ Rash ____ / ____
- ☐ ☐ Red Face ____ / ____
- ☐ ☐ Sensitive to Poison Ivy/Oak ____ / ____
- ☐ ☐ Shingles ____ / ____
- ☐ ☐ Skin Darkening ____ / ____
- ☐ ☐ Strong Body Odor ____ / ____
- ☐ ☐ Hair Loss ____ / ____
- ☐ ☐ Vitiligo ____ / ____
- ☐ ☐ Eczema ____ / ____
- ☐ ☐ Psoriasis ____ / ____
- ☐ ☐ Melanoma ____ / ____
- ☐ ☐ Skin Cancer ____ / ____
- ☐ ☐ Other: _____ ____ / ____

DISEASES/DIAGNOSIS/CONDITIONS *(continued...)*

Neurologic/Mood

☐ ☐ Depression ____ / ____
☐ ☐ Anxiety ____ / ____
☐ ☐ Bipolar Disorder ____ / ____
☐ ☐ Schizophrenia ____ / ____
☐ ☐ Headaches ____ / ____
☐ ☐ Migraines ____ / ____
☐ ☐ ADD/ADHD ____ / ____
☐ ☐ Autism ____ / ____
☐ ☐ Mild Cognitive Impairment ____ / ____
☐ ☐ Memory Problems ____ / ____
☐ ☐ Parkinson's Disease ____ / ____
☐ ☐ Multiple Sclerosis ____ / ____
☐ ☐ ALS ____ / ____
☐ ☐ Seizures ____ / ____
☐ ☐ Other: _____ ____ / ____

Female Reproductive

☐ ☐ Breast Cysts ____ / ____
☐ ☐ Breast Lumps ____ / ____
☐ ☐ Breast Tenderness ____ / ____
☐ ☐ Breast Implants ____ / ____
☐ ☐ Ovarian Cysts ____ / ____
☐ ☐ Poor Libido *(sex drive)* ____ / ____
☐ ☐ Vaginal Discharge ____ / ____
☐ ☐ Vaginal Odor ____ / ____
☐ ☐ Vaginal Itch ____ / ____
☐ ☐ Vaginal Pain with Sex ____ / ____
☐ ☐ Other: _____ ____ / ____

Male Reproductive

☐ ☐ Discharge from Penis ____ / ____
☐ ☐ Ejaculation Problems ____ / ____
☐ ☐ Genital Pain ____ / ____
☐ ☐ Impotence ____ / ____
☐ ☐ Prostate or Urinary Infection ____ / ____
☐ ☐ Lumps in Testicles ____ / ____
☐ ☐ Poor Libido *(sex drive)* ____ / ____
☐ ☐ Other: _____ ____ / ____

Injuries *(check box if yes and provide date/description)*

☐ ☐ Back Injury ____ / ____ _____
☐ ☐ Head Injury ____ / ____ _____
☐ ☐ Neck Injury ____ / ____ _____
☐ ☐ Broken Bones ____ / ____ _____
____ / ____ _____
____ / ____ _____
☐ ☐ Other: _____ ____ / ____

Surgeries *(check box if yes and provide date of surgery)*

☐ ☐ None
☐ ☐ Appendectomy ____ / ____
☐ ☐ Hysterectomy +/– Ovaries ____ / ____
☐ ☐ Gall Bladder ____ / ____
☐ ☐ Hernia ____ / ____
☐ ☐ Tonsillectomy ____ / ____
☐ ☐ Dental Surgery ____ / ____
☐ ☐ Joint Replacement: Knee / Hip ____ / ____
☐ ☐ Heart Surgery: Bypass Valve ____ / ____
☐ ☐ Angioplasty or Stent ____ / ____
☐ ☐ Pacemaker ____ / ____
☐ ☐ Other: _____ ____ / ____

Preventative Tests *(check box if yes and provide test date)*

☐ ☐ Blood Tests ____ / ____
☐ ☐ Full Physical Exam ____ / ____
☐ ☐ X–Ray ____ / ____ *Body Part?* _____
☐ ☐ Dental X–Ray ____ / ____
☐ ☐ Bone Density ____ / ____
☐ ☐ Colonoscopy ____ / ____
☐ ☐ Cardiac Stress Test ____ / ____
☐ ☐ EKG ____ / ____
☐ ☐ Hemoccult Test *(stool test for blood)* ____ / ____
☐ ☐ MRI ____ / ____
☐ ☐ CT Scan ____ / ____
☐ ☐ Upper Endoscopy ____ / ____
☐ ☐ Upper GI Series ____ / ____
☐ ☐ Ultrasound ____ / ____
☐ ☐ Eye Exam ____ / ____
☐ ☐ Breast Exam ____ / ____
☐ ☐ Prostate Exam ____ / ____
☐ ☐ Other: _____ ____ / ____

Blood Type

☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ unknown

NOTICE OF PRIVACY PRACTICES (HIPAA) FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Alternative Health Care Center (AHCC) is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide patients with notice of legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT: We may disclose your health information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. It may be necessary to seek consultation regarding your condition from other health care providers associated with AHCC. Substitute health care providers within AHCC may provide treatment to our patients in the event of your primary health care provider's absence due to vacation, sickness or other emergency situations.

PAYMENT: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to AHCC for health care services rendered. The billing statement contains medical information such as diagnosis, date of injury or condition and codes which describe the health care services received.

WORKERS' COMPENSATION: We may disclose your health information in order to comply with State Workers' Compensation Laws.

EMERGENCIES OR DECEASED PERSONS: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death. We may disclose your health information to coroners or medical examiners.

PUBLIC HEALTH & SAFETY: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the FDA problems with products and reactions to medications, reporting disease or infection exposure, and preventing or lessening a serious threat to the health or safety of a particular person or to the general public.

JUDICIAL & ADMINISTRATIVE PROCEEDINGS: We may disclose your health information in administrative or judicial proceedings.

LAW ENFORCEMENT & SPECIALIZED GOVERNMENT AGENCIES: We may disclose your health information to law enforcement officials for purposes such as identifying/locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes, or for military, national security, prisoner and government benefits purposes.

CHANGE OF OWNERSHIP: In the event that AHCC is sold, your health information will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS: You have the right to: request restrictions on certain uses and disclosures of your health information (however, AHCC is not required to agree to the restriction(s) that you request); inspect and copy your health information; request that AHCC amend your protected health information (however, AHCC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and how you can disagree with the denial); request a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES: AHCC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, AHCC is required by law to comply with this Notice. AHCC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

I HAVE READ THE PRIVACY NOTICE AND UNDERSTAND MY RIGHTS CONTAINED IN THE NOTICE: By way of my signature, I provide AHCC with my authorization and consent to use and disclose my protected health care information as described in the Privacy Notice.

I authorize AHCC to use/disclose health information about me to (family member/friend): _____

Patient's Printed Name: _____

Patient's Signature _____ **Date:** _____