Spark of Life Chiropractic, PLLC

Dr. Katheirne Phillips, D.C.

5215 North Sabino Canyon Road, Suite 110

Tucson, AZ 85750

Name: _____
I preferred to be Called:_____
Address_____
City_____ State _____ ZIP_____
Gender: Male Female Age _____ Height _____ Weight _____
DOB _____ Home Phone (_____) _____ Cell (_____)
_____Email_____
Occupation_____ Emergency Contact name
_____ Emergency Number (____) _____ Primary Care
Physician_____

Medication List: Please list the name of each current prescribed and over the counter medications and/or supplements, prescribed use and any side effects/reactions Medication Purpose of Taking Medication Any Side-Effects

_____
_____
_____

HISTORY

What is the main problem/symptom that you are having? (Be as specific as possible)

_____
_____
_____

Related to (circle one) Work Sport Auto Accident Trauma Chronic

Is this due to an auto accident: Y/N If so, when did the accident occur? _____

List other symptoms you are currently experiencing even if not related to complaint listed above:

_____
_____
_____

Describe what you are feeling (diffuse, dull, achey, sharp, burning, cramping)?

_____
_____
_____

When did this begin?

_____
_____
_____

How did this begin?

_____
_____
_____

Have you had this or similar conditions in the past? Yes No If yes, when?_____

What makes your condition worse?

_____
_____

What makes your condition better?

_____
_____

Do you experience Numbness or Tingling? Yes No If yes, where?

_____

Does it radiate down the arm(s), leg(s), back or other?

_____

SYMPTOM INTENSITY: Please circle the number describing the intensity of symptoms. None/ 0 1 2 3 4 5 6 7 8 9 10/Unbearable

When you are awake, how often are you feeling these symptoms? (0-100%)

_____

Does this affect you at night? Yes No When do you experience this throughout the day (AM/PM/ All Day)? _____

How many days per week do you experience your main complaint?

_____

Is this progressively getting worse? Yes No

Is your condition: Constant or comes & goes

Have you had any treatment for this problem in the past? Yes No
If yes, when/by whom? _____

How did the previous method(s) work for you?
_____

Are there any conditions that run in your family? Yes No If yes, what condition(s) and what family member?
_____
_____
_____

When was your last: Physical _____ Blood/lab work _____ X-ray _____ MRI _____

Have you been treated for your current condition before? Yes No If yes, when/by whom?
_____

Surgical History: Please list the type and reason of surgery, and year performed (e.g. left breast for cancer in 2004)
_____
_____
_____

REVIEW OF SYSTEMS

Changes in or loss of smell? Normal, Loss, increased or decreased?

Monovision correction? Yes No

Visual changes or loss of vision? Yes NO

Difficulty with visual focus or acuity Yes No

Double vision? If yes, in which direction. Yes No

Dry eyes, dry mouth or excessive tearing or saliva? Yes No

Weakness or numbness of the face? Yes No

Difficulty hearing or ringing in your ears? Yes No

Maintaining balance with or without head movements? Yes No

Light headedness/dizziness when rising from a lying or seated position? Yes No

Sensations of spinning? Yes No If yes, which direction? _

Difficulty swallowing foods? Yes No

Bladder control issues? Yes No

Changes in sexual function or ability? Yes No

Difficulty shrugging or raising your shoulders or arms? Yes No

Slurring your words or your tongue feeling thick? Yes No

Sweaty hands or feet? Yes No

Cold hands or feet? Yes No

Noticeable sweating difference on the right or the left? Yes No

Please Circle any of the following conditions or complaints that you have or are experiencing

ADD/ADHD	Carpal Tunnel	Blurred Vision	Heart Disease
Adrenal Disorder	Cancer _____	Buzzing in Ear (s)	Hepatitis A, B, C
Anxiety	Celiac Disease	Dizziness (sitting up/ standing up)	Herpes
Arthritis	Chest Pains	Double Vision	High Blood Pressure
Asthma	Chronic Fatigue	Dyslexia	Hip Replacement

Atypical Facial Pain	Colitis/Diverticulitis	Ear Infections	HIV/AIDS
Arm or Leg Pain	Compression Fractures	Fibromyalgia	Immune Deficiency
Autoimmune Condition	Concussion	Food Sensitivity	Multiple Sclerosis
Balance Problems	Connective Tissue	Fusions (spinal)	Neck Pain
Balance Problems	COPD Depression	Gout	Osteoporosis/Penia
Bleeding Disorder	Diabetes (Type 1 or 2)	Headache	Regional Pain Syndrome (CRPS)
Blood Sugar Issues	Digestive Issues	Gall Bladder Issue	Rotator Cuff Issues
Insomnia	Kidney Disease	Low Back Pain	Shoulder Pain
Joint Pain	Liver Disease	Migraine	Stroke/TIA
Trigeminal Neuralgia	TMJ	Thyroid Issues	STI/STD
Tremors	Tuberculosis	Numbness in Hands or Feet	Vertigo

INFORMED CONSENT FOR EXAM/CONSULTATION/CHIROPRACTIC TREAMENT AND CARE

I herby request and consent to the performance of a chiropractic neurology examination, including but not limited to diagnostic x-rays on me, or the patient named below, for whom I am legally responsible to sign for. This consent is made to be formed by one of the doctors of chiropractic name above.

I further request and consent for various modes of physical therapy and chiropractic neurology procedures/techniques by the chiropractor named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with serving as back-up or in consultation with the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office, hospital, clinic or location. Our office is required by the Federal HIPAA Laws to have your signed and dated permission to let other team members access your PHI. This authorization to allow other healthcare provers access to your PHI for diagnosis and treatment may be revoked by you at any time, by advising our office (privacy officer) of this revocation in writing.

I understand and am informed that, as in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc inures, strokes, dislocations and sprains. I do not expect the doctors(s) to be able to anticipate and explain all risks and complication, and I wish to rely on the doctor to exercise judgement during the course of t he procedure which the doctor feels at the time, base upon the facts know then, is in the my interest.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-name procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Spark of Life Chiropractic, PLLC.

Patient Name (Print) : _____ Date:_____

Patient's Signature: _____ Date:_____

Spark of Life Chiropractic, PLLC Dr.

Katherine Phillips, D.C.

5215 North Sabino Canyon Road, Suite 110

Tucson, AZ 85750

Ph: (520) 306-6848

PROTECTED HEALTH INFORMATION (PHI) AUTHORIZAITON

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy laws. Patient confidentially and privacy applies to any protected health information (PHI). Federal Laws now require signed and dated authorization from patients in several aspects of patient care, transmission of medical information, confidentially, and patient rights relating to their medical records. In order for this authorization to be valid you must sign, date and indicate an expiration date or event for your authorization. The privacy rules require that the doctor post the notice in a prominent place.

PRIVACY NOTICE

I acknowledge that Spark of Life Chiropractic, PLLC located at 5215 North Sabino Canyon Road, Suite 110, Tucson, AZ 85750 has presented me with a copy of their privacy practices and I have been able to read the practice policies notice that is posted on the waiting room wall. This notice explains how my protected health information (PHI) may be used and what Spark of Life Chiropractic, PLLC responsibilities are regarding my privacy rights. I have been allowed to request a printed sheet of Spark of Life Chiropractic, PLLC privacy notice. Indicated weather you are the parent of a legal guardian of the patient or minor.

Date: _____ Signature: _____

Legal Guardian/Parent Name/Relationship:_____

Patient Refusal To Sign Acknowledgement

Date:_____ Employee/Doctor Name:_____

Authorization To Verbally Communicate With A Family Member/Friend

Our office is required by the Federal HIPAA Laws to have you sign wheather you desire to have your PHI discussed with a family member or friend. If you authorize our office to speak with a family member or friend please indicate the name of the person, relationship to you and what may be discussed. If you have any aspects of your PHI that you do not want disclosed, please list the specific aspects of your PHI below that you want "restricted". This authorization may be revoked by you at any time, by advising our office (privacy officer) of this revocation in writing. If you choose to not sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment or payment.

__ YES, I authorize verbal communication with the following person(s)

__ Verbal __ Telephone Number:

Name of family or friend: _____ Relationship: _____

PHI Restrictions: _____

Patient Signature: _____ Date: _____

Expiration for Authorization:

__ No Date

__ Date: _____

In the case an emergency whom may we contact? Please list the name, address, phone number and relationship of the individual listed.

Emergency Contact:

Name:_____ Phone: _____

Address: _____

Relationship: _____

Alternate Emergency Contact:

Name: _____ Phone: _____

Address: _____

Relationship: _____