Schroeder Family Chiropractic

Dr. W. Scott Schroeder, D.C. Dr Marc L. Schroeder, D. C.

Patient Information Please write name as it appears on your insurance card.

First Name: _____ MI: ____ Last Name: _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

E-mail: _____ Preferred method of contact: Home Work Cell Email Text Other

SS#: _____ DOB: _____ Age: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed

Spouse Name: _____ Phone #: _____

Employer: _____ ☐ F / T ☐ P / T Occupation: _____

If Student, School: _____ ☐ F / T ☐ P / T

Primary Care Physician: _____ Phone #: _____ Last Seen: _____

Referred By: _____ Is this person a patient? Yes No

Responsible Party Information Patient's relationship to responsible party: ☐Self ☐Spouse ☐ Dependent

(If you are the responsible party, check the box labeled "Self" and skip this section. Sign and date the bottom of the page.)

First Name: _____ MI: ____ Last Name: _____ Home Phone: _____

Street: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SS#: _____ DOB: _____ Age: _____ Occupation: _____

Marital Status: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed Sex: ☐ Male ☐ Female

Employer / Employer Address: _____

Are you covered by Medicare? Yes No

Assignment and Release: I hereby assign, transfer, and set over to Schroeder Family Chiropractic, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature: _____ Date: _____

Consent for Chiropractic Treatment and Care

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including but not limited to various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible for) by the doctor or chiropractor named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back up for the doctor or chiropractor named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor named below or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. 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, disc injuries, strokes, dislocations and sprains. I don't expect the doctor to be able to anticipate and explain all of the risks and complications, and I 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 have read or have been read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above 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.

Appointment Reminders, Health Care Information, Related News and Marketing Authorization

From time to time our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. Your chiropractors, medical doctors and members of the practice staff may need to use your health information including your name, address, phone number and your clinical records for the purpose of marketing products and services.

Your chiropractors, medical doctors and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. Contact maybe by phone, mail, email or other means. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information. By your signature, you are authorizing us to contact you at home, work or cell phone and to leave a message on an answering device or with an individual.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524). By signing I acknowledge that I have received a copy of this notice.

Notice or Privacy Practices for Protected Health Information

By signing below I acknowledge that I have received a copy of this notice.

This notice is effective as of this _____day of _____(month) 201___. This authorization will expire six years after the date on which you last received services from us. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient Name Printed	**Patient Signature**	**Date**
Patient Representative Name Printed	**Representative Signature**	**Date**

Relationship or Authority of Patient's Representative_____

X-Ray Consent Form

The Doctor has explained the purpose of the x-rays about to be taken. The x-rays will be used as a diagnostic tool to assist the doctor in determining the health care that is needed. I also understand that the x-rays will remain the property of the clinic and may be checked out at the discretion of the clinic director. I am not pregnant at this time and I fully understand the above and consent to diagnostic X-rays.

Patient Name Printed	**Patient Signature**	**Date**

By the Doctor initialing here the patient did not need X-Rays._____

Name of Doctors treating this patient: Dr. W. Scott Schroeder, D.C. or Dr. Marcus L Schroeder, D.C.
Additional Doctors:_____

Case History

Family History

Yes No Diabetes
Yes No Thyroid Disease
Yes No TB
Yes No Kidney Disease
Yes No High Blood Pressure
Yes No Heart Disease
Yes No Musculoskeletal Disease
Yes No Cancer
Yes No Other Family History

General History

Yes No Height Change
Yes No Weight Change
Yes No Fever/Chills/Sweats
Yes No Allergies
Yes No Anemia
Yes No Bleeding/Bruising
Yes No Malaise/Fatigue/Weakness
Yes No HIV Positive
Yes No Other General

Endocrine History

Yes No Heat/Cold Intolerance
Yes No Diabetes
Yes No Thyroid Disease
Yes No Neck/Surgery/Irradiation
Yes No Change in secondary sex characteristics
Yes No Other Glandular Problems

Eye Ear Nose and Throat

Yes No Visual Problems
Yes No Eye Redness, Swelling, Tearing, Itching
Yes No Pain in the eyes
Yes No Other eye problems
Yes No Difficulty Hearing or Deafness
Yes No Ringing in ears/Dizziness
Yes No Ear Growths/ Pain/ Discharge
Yes No Nose Bleeds
Yes No Sneezing
Yes No Nose Growths/ Pain/ Discharge
Yes No Sinus Infections
Yes No Hoarseness, Change in Voice
Yes No Difficult Chewing/Swallowing
Yes No Enlarged or Painful Glands
Yes No Change in Taste
Yes No Growth/Lesions in throat/mouth
Yes No Dental Problems
Yes No Other problems Throat/Mouth

Patient Name:_____

Gastrointestinal System

Yes No Change in Appetite
Yes No Food Intolerance
Yes No Nausea/Vomiting
Yes No Vomiting of Blood
Yes No Ulcers, diagnosed by_____
Yes No Indigestion, Heartburn
Yes No Abdominal Pain (Stomach)
Yes No Abdominal Swelling
Yes No Abnormal Flatulence (gas)
Yes No Change in Bowel Habits
Yes No Change in Stool, Diarrhea
Yes No Hernia
Hiatal
Femoral
Inguinal
Diagnosis by_____
Yes No Hemorrhoids
Yes No Gallbladder Disease
Diagnosis by_____
Yes No Liver Disease
Diagnosis by_____
Yes No Pancreas Disorder/Inflammation
Yes No Alcohol Intake, _____x per week
Yes No Other GI Problems

Pulmonary System

Yes No Difficulty Breathing
Yes No Coughing/ Wheezing/ Asthma
Yes No Coughing up Blood
Yes No TB exposure/ + Test or Xray
Yes No Respiratory Infections/pneumonia
Yes No Cigarette Smoking
#Day_____# Years_____
Yes No Other Tobacco Use
Yes No Exposure to Dangerous Fumes, Toxic Chemicals, Pollution
Yes No Other Pulmonary Problems

Cardiovascular System

Yes No Shortness of Breath
Yes No Chest Pain or Discomfort
Yes No Palpation
Yes No Edema
Yes No Fainting
Yes No Calf Pain while walking
Yes No High Blood Pressure
Yes No Past Heart Disease
Yes No Rheumatic Fever
Yes No Other Heart Diseases, Problems

Intake Date:_____

Case History

Breast Male and Female

Yes No Lumps/Masses/Tenderness/Pain
Yes No Dimples in Breast
Yes No Change in Color/Size/Shape
Yes No Nipple Discharge
Yes No Other Breast Problems

Reproductive System

Yes No Genital Lesions
Yes No Genital Mass/Growth/Pain
Yes No Venereal Disease (VD)
Yes No Change in Sex Drive
Yes No Pain During Sex
Yes No Birth Control
Method_____
Yes No Other Reproductive Problems

Skin Hair Nails System

Yes No Change in Skin Texture/ Temp
Yes No Excessive Dryness/Sweating
Yes No Unusual Skin Coloration
Yes No Rashes/Itching/Lesions
Yes No Skin Growths
Yes No Mole Changes
Yes No Skin Cancer
Yes No Change in Hair Texture/Condition
Yes No Change in Hair Growth/Loss
Yes No Change in shape/color of finger/toenails
Yes No Other Problems

Neurological System

Yes No Headaches
Yes No Seizures
Yes No Ticks/Spasms
Yes No Dizziness/Fainting
Yes No Unusual Weakness
Yes No Head Injury
Yes No Stroke
Yes No Other Neurological Problems

Musculoskeletal System

Yes No Joint Stiffness
Yes No Joint Pain
Yes No Joint Swelling

Yes No Muscle Cramps
Yes No Muscle Weakness

Yes No Muscle Wasting
Yes No Neck Pain
Yes No Upper/Mid Back Pain
Yes No Low Back Pain
Yes No Buttock Pain
Yes No Shoulder/Arm/ Hand Problems
Yes No Leg/Knee/Foot/Ankle Problems

Musculoskeletal System

Yes No Fractures/Sprains/Dislocations
Yes No Other Injuries/ Musculoskeletal Problems

Hospitalizations Medications

List Any Hospitalizations
1._____
2._____
3._____
4._____

List Any Medications (including OTC)

1._____
2._____
3._____

Psychological History

Yes No Anxiety
Yes No Depression
Yes No Hospitalization, B/C Mental
Yes No Other Psychological Problems

Diet Vitamins

Yes No Do you eat meals sporadically
Yes No Have an unusual appetite
Yes No Skip Breakfast
Yes No Eat Between Meals
Yes No Eat Late night snacks
Yes No On a special diet
Yes No Take Supplements

Implants or Orthopedics

Yes No Breast Implants
Yes No Cardiac Implants ex. Pacemaker
Yes No Orthopedic Implants
Yes No Supports or Orthotics

Patient Name:_____

Intake Date:_____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

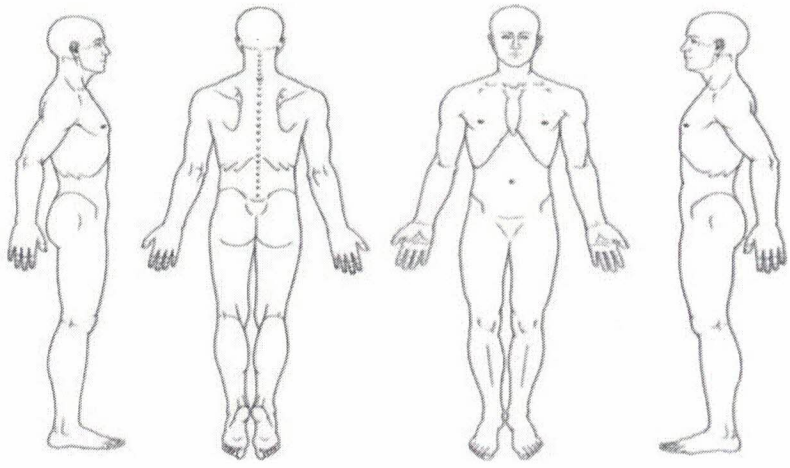
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Schroeder Family Chiropractic
Atlas Rehab and Medical
1982 N. Hwy 190
Covington, LA 70433
985-871-7411

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____ **DOB:** _____

PHI authorized for use or disclosure
____All PHI in record ____Progress/Treatment Notes ____ X-ray test/ Reports
____Lab Tests ____Discharge Summary ____ER notes ___ Other: _____

Expiration Date of Authorization
This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

Schroeder Family Chiropractic
Atlas Rehab and Medical
1982 N. Hwy 190
Covington, LA 70433
985-871-7411

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Schroeder Family Chiropractic / Atlas Rehab and Medical or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date