COVENANT CHIROPRACTIC CENTER - New Patient Intake

Name: _____ Today's Date: _____

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

Home Telephone: _____ Work: _____ Cell: _____

Email Address: _____ Sex:_____

Birthdate: _____ Age:_____ Occupation:_____

Employer Name and Address: _____

Marital Status: _____ Spouses Name: _____

Emergency Contact: _____

Emergency Contact Phone #: _____ Relation to Patient: _____

Have you seen a Chiropractor before? Yes No

If yes, when? _____ What were you treated for?_____

_____

How did you hear about us?: _____

YOUR HEALTH HISTORY

Please check all symptoms you have ever had, even if they do not seem related to your current problems.

☐ Headaches	☐ Pins and Needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold Hands	☐ Cold Feet
☐ Cold Sweats	☐ Constipation	☐ Problem Urinating	☐ Hot Flashes
☐ Mood swings	☐ Lights bother eyes	☐ Menstrual irregularity	☐ Heartburn

Main Complaint: _____

List any medications you are taking: _____

Do you take nutritional supplements and if so what? _____

Have you been in a car accident recently? Yes ___ No ___ If so, when? _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.

Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Name (Print): _____ Patient Signature: _____

Guardian Name (Print): _____ Guardian Signature: _____

Covenant Chiropractic Center, PLLC
11133 I-45 South, Suite 120
Conroe, TX 77302
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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. “Protected Health Information” is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. For Example: We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations included, as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Printed Name (Patient/Parent/Guardian)_____Date_____
Signature (Patient/Parent/Guardian)_____