

# 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.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and Needles in legs | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Back pain              | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Buzzing in ears          | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Neck stiff               | <input type="checkbox"/> Cold Hands             | <input type="checkbox"/> Cold Feet       |
| <input type="checkbox"/> Cold Sweats              | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Problem Urinating      | <input type="checkbox"/> Hot Flashes     |
| <input type="checkbox"/> Mood swings              | <input type="checkbox"/> Lights bother eyes       | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> 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? \_\_\_\_\_

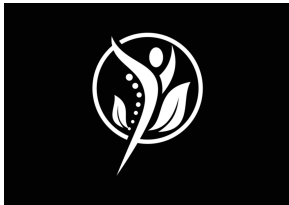
This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.

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: \_\_\_\_\_



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**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) \_\_\_\_\_