DOUGLAS O. PITT, B.S., D.C.
Auburn Chiropractic Health Clinic, Inc.
Glendean Shopping Center
764 East Glenn Ave.
Auburn, Alabama 36830
Telephone: (334) 501-4691
Fax: (334) 501-4693

Patient Information

Welcome to our office! Please complete all questions.

Who may we thank for referring you? ________________________________

Name: ____ Date: ______________

Address: ______________________________ City: ______________ State: _____ Zip: ________

Home Phone: ____________________________ Work Phone: ____________________________

Cell or Alternate Phone: ________________________ Email: _______________________________

Birth date: __________________ Age: __________ Height: ______ft. ______in. Weight: ___________lbs.

SSN: ________ - ______ - _________ Sex: M or F Marital Status: Married Single Divorced Widowed

Place of Employment ______________________________ Employer Phone Number ________________

Method of payment for first visit: Cash _____ Check _____ Credit Card _____

Financially responsible party – Name: _________________________________ Relationship: __________
Address: ____
Phone Number: ____
Date of Birth on Insurance Card and/or birth date of Guarantor: ______________________________

List your chief complaints in order of severity:

1. ____ For how long? ________________

2. ____ For how long? ________________

Where is the pain? _________________________ Does it spread? Yes ____ No ____ If yes, where?__________
Do you have numbness? Yes ____ No ____ If yes, where? ______________________________________
Is there pain when you cough or sneeze? Yes ____ No ____ If yes, where? ___________________________
Is there pain when you go from sitting to standing? Yes ____ No ____ If yes, where? ___________________

Do you have headaches? Yes ____ No ____ If yes, circle all that apply:
TENSION THROB SINUS MIGRAINE OTHER: _________________________
Indicate below any functions that aggravate or are aggravated by your condition (circle all that apply):
Walking Step Climbing Driving Working Recreation Bowel Movements Digestion
Vision Breathing Sinuses Hearing Smelling Sleeping

Patient Information – Page 2

Name of Insurance Company: ____

Address: ______________________________ City: __________________ State: _____ Zip: ___________

Phone Number: _________________________ Group Policy Name: _______________________________

Group ID# _____________________________ Personal/Member ID# ______________________________

Name of Insured: ________________________________ Is patient a dependent under this policy? Yes__ No __

I/we hereby authorize and direct my insurance benefits to be paid directly to Auburn Chiropractic Health Clinic for an unexpired period of time. I understand that I am responsible for any portion of my bill that my insurance company does not pay or for non-covered services. Failure to make payments according to office policy is basis for legal action, and I agree to pay all costs of collection including reasonable attorney fees and court costs. I waive my right to claim exemption under the Constitution and Law of the State of Alabama or any other state.

I agree to pay for services rendered to the above-mentioned patient as the charges are incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my, or my child's, care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby give permission to Dr. Pitt (and whomever they may designate as his assistants) to administer treatment, and to perform such general procedures as they may deem necessary in the diagnosis and/or treatment of my, or my child's, condition. I also certify that no guarantee has been made as to the results that may be obtained.

I hereby verify that I have read and reviewed the above information and represent the same is true, correct, and complete. I understand that Dr. Pitt will be relying on the above information in his treatment of me. Should Auburn Chiropractic Health Clinic file insurance on my behalf, I hereby give permission to Auburn Chiropractic Health Clinic to release any information requested by my insurance company acquired in the course of my examination and/or treatment.

This information is true and accurate to the best of my knowledge.

Patient's or Guardian's Signature ____ Date ___________

Auburn Chiropractic Health Clinic, Inc.
Dr. Douglas Owens Pitt

764 E. Glenn Ave.
Auburn, AL 36830

Phone (334) 501-4691
Fax (334) 501-4693

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if, during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____, have read and fully understand the above statements.
(PRINT NAME)

I therefore accept chiropractic care on this basis.

____ _______/_______/__________
(SIGNATURE) (DATE)

Consent to Evaluate and Adjust a Minor Child

I, ____, being the parent or legal guardian of
(PRINT NAME)
____, have read and fully understood the above terms of
(PRINT CHILD'S NAME)
acceptance and hereby grant permission for my child to receive chiropractic care.

____ _______/_______/__________
(SIGNATURE) (DATE)

SYSTEMS SURVEY

Patient ______________________________ Doctor _________________________ Date __________

Birth Date _____/ _____/ _____ Approx. Weight ___________lbs. Vegetarian: Yes ❒ No ❒

INSTRUCTIONS: If no symptom in a group applies to you, then check the box at the top of that group. If you have symptoms, then number only the boxes that apply to you. Leave blank if you don't have the problem.

- Write **1** in the box for **MILD** symptoms (occurred once or twice last 6 months)
- Write **2** in the box for **MODERATE** symptoms (occurred once or twice last month)
- Write **3** in the box for **SEVERE** symptoms (chronic, occurred once or twice last week)

GROUP 1

❒ Check this box only if **no** symptom in Group 1 applies to you.

1 ☐ Acid foods upset
2 ☐ Get chilled often
3 ☐ "Lump" in throat
4 ☐ Dry mouth, eyes, nose
5 ☐ Pulse speeds after meal
6 ☐ Keyed up – fail to calm
7 ☐ Cut heals slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach often

GROUP 2

❒ Check this box only if **no** symptom in Group 2 applies to you.

21 ☐ Joint stiffness on arising
22 ☐ Muscle, leg, toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seem hungry; feel "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

❒ Check this box only if **no** symptom in Group 3 applies to you.

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep - hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression – "blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

❒ Check this box only if **no** symptom in Group 4 applies to you.

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed rooms
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles, worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black and blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head, or "ringing in ears"
72 ☐ Tension under the breast-bone, or feeling of "tight-ness", worse on exertion

SYSTEMS SURVEY – PAGE 2

GROUP 5

❒ Check this box only if **no** symptom in Group 5 applies to you.

- 73 ☐ Dizziness
- 74 ☐ Dry skin
- 75 ☐ Burning feet
- 76 ☐ Blurred vision
- 77 ☐ Itching skin and feet
- 78 ☐ Excessive falling hair
- 79 ☐ Frequent skin rashes
- 80 ☐ Bitter, metallic taste in mouth in mornings
- 81 ☐ Bowel movements painful or difficult
- 82 ☐ Worrier, feels insecure
- 83 ☐ Feeling queasy; headache over eyes
- 84 ☐ Greasy foods upset
- 85 ☐ Stools light colored
- 86 ☐ Skin peels on foot soles
- 87 ☐ Pain between shoulder blades
- 88 ☐ Use laxatives
- 89 ☐ Stools alternate from soft to watery
- 90 ☐ History of gallbladder attacks or gallstones
- 91 ☐ Sneezing attacks
- 92 ☐ Dreaming, nightmare type bad dreams
- 93 ☐ Bad breath (halitosis)
- 94 ☐ Milk products cause distress
- 95 ☐ Sensitive to hot weather
- 96 ☐ Burning or itching anus
- 97 ☐ Crave sweets

GROUP 6

❒ Check this box only if **no** symptom in Group 6 applies to you.

- 98 ☐ Loss of taste for meat
- 99 ☐ Lower bowel gas several hours after eating
- 100 ☐ Burning stomach sensations, eating relieves
- 101 ☐ Coated tongue
- 102 ☐ Pass large amounts of foul-smelling gas
- 103 ☐ Indigestion ½ to 1 hour after eating; may be 3-4 hrs.
- 104 ☐ Mucous colitis or “irritable bowel”
- 105 ☐ Gas shortly after eating
- 106 ☐ Stomach “bloating” after eating

GROUP 7

❒ Check this box only if **no** symptom in Group 7 applies to you.

(A)

- 107 ☐ Insomnia
- 108 ☐ Nervousness
- 109 ☐ Can’t gain weight
- 110 ☐ Intolerance to heat
- 111 ☐ Highly emotional
- 112 ☐ Flush easily
- 113 ☐ Night sweats
- 114 ☐ Thin, moist skin
- 115 ☐ Inward trembling
- 116 ☐ Heart palpitates
- 117 ☐ Increased appetite without weight gain
- 118 ☐ Pulse fast at rest
- 119 ☐ Eyelids and face twitch
- 120 ☐ Irritable and restless
- 121 ☐ Can’t work under pressure

(B)

- 122 ☐ Increase in weight
- 123 ☐ Decrease in appetite
- 124 ☐ Fatigue easily
- 125 ☐ Ringing in ears
- 126 ☐ Sleepy during day
- 127 ☐ Sensitive to cold
- 128 ☐ Dry or scaly skin
- 129 ☐ Constipation
- 130 ☐ Mental sluggishness
- 131 ☐ Hair coarse, falls out
- 132 ☐ Headaches upon arising, wear off during day
- 133 ☐ Slow pulse, below 65
- 134 ☐ Frequency of urination
- 135 ☐ Impaired hearing
- 136 ☐ Reduced initiative

(C)

- 137 ☐ Failing memory
- 138 ☐ Low blood pressure
- 139 ☐ Increased sex drive
- 140 ☐ Headaches, “splitting or rending” type
- 141 ☐ Decreased sugar tolerance

(D)

- 142 ☐ Abnormal thirst
- 143 ☐ Bloating of abdomen
- 144 ☐ Weight gain around hips or waist
- 145 ☐ Sex drive reduced or lacking
- 146 ☐ Tendency to ulcers, colitis
- 147 ☐ Increased sugar tolerance
- 148 ☐ Women: menstrual disorders
- 149 ☐ Young girls: lack of menstrual function

(E)

- 150 ☐ Dizziness
- 151 ☐ Headaches
- 152 ☐ Hot flashes
- 153 ☐ Increased blood pressure
- 154 ☐ Hair growth on face or body (female)
- 155 ☐ Sugar in urine (not diabetes)
- 156 ☐ Masculine tendencies (female)

(F)

- 157 ☐ Weakness, dizziness
- 158 ☐ Chronic fatigue
- 159 ☐ Low blood pressure
- 160 ☐ Nails weak, ridged
- 161 ☐ Tendency to hives
- 162 ☐ Arthritic tendencies
- 163 ☐ Perspiration increase
- 164 ☐ Bowel disorders
- 165 ☐ Poor circulation
- 166 ☐ Swollen ankles
- 167 ☐ Crave salt
- 168 ☐ Brown spots or bronzing of skin
- 169 ☐ Allergies,tendency to asthma
- 170 ☐ Weakness after colds or flu
- 171 ☐ Exhaustion – muscular and nervous
- 172 ☐ Respiratory disorders

SYSTEMS SURVEY – PAGE 3

GROUP 8

❐ Check this box only if **no** symptom in Group 8 applies to you.

- 173 ☐ Apprehension
- 174 ☐ Irritability
- 175 ☐ Morbid fears
- 176 ☐ Never seem to get well
- 177 ☐ Forgetfulness
- 178 ☐ Indigestion
- 179 ☐ Poor appetite
- 180 ☐ Craving for sweets
- 181 ☐ Muscular soreness
- 182 ☐ Depression; feelings of dread
- 183 ☐ Noise sensitivity
- 184 ☐ Acoustic hallucinations
- 185 ☐ Tendency to cry without reason
- 186 ☐ Hair is coarse and/or thinning
- 187 ☐ Weakness
- 188 ☐ Fatigue
- 189 ☐ Skin sensitive to touch
- 190 ☐ Tendency toward hives
- 191 ☐ Nervousness
- 192 ☐ Headache
- 193 ☐ Insomnia
- 194 ☐ Anxiety
- 195 ☐ Anorexia
- 196 ☐ Inability to concentrate; confusion
- 197 ☐ Frequent stuffy nose; sinus infections
- 198 ☐ Allergy to some foods
- 199 ☐ Loose joints

FEMALE ONLY

❐ Check this box only if **no** symptom in this group applies to you.

- 200 ☐ Very easily fatigued
- 201 ☐ Premenstrual tension
- 202 ☐ Painful menses
- 203 ☐ Depressed feelings before menstruation
- 204 ☐ Menstruation excessive and prolonged
- 205 ☐ Painful breasts
- 206 ☐ Menstruate too frequently
- 207 ☐ Vaginal discharge
- 208 ☐ Hysterectomy/ovaries removed (write number 3)
- 209 ☐ Menopausal hot flashes
- 210 ☐ Menses scanty or missed
- 211 ☐ Acne, worse at menses
- 212 ☐ Depression of long standing

MALE ONLY

❐ Check this box only if **no** symptom in this group applies to you.

- 213 ☐ Prostate trouble
- 214 ☐ Urination difficult
- 215 ☐ Night urination frequent
- 216 ☐ Depression
- 217 ☐ Pain on inside of legs or heels
- 218 ☐ Feeling of incomplete bowel evacuation
- 219 ☐ Lack of energy
- 220 ☐ Migrating aches and pains
- 221 ☐ Tire too easily
- 222 ☐ Avoids activity
- 223 ☐ Leg nervousness at night
- 224 ☐ Diminished sex drive

IMPORTANT

Please list the five (5) main complaints you have in the order of their importance.

If you have **no** complaints, please check here. ❐

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION WITH MARKETING PROVISION

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

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information, including all of your clinical records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practices.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you at home, at work, or on a mobile telephone, to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home or at work to receive an appointment reminder, a message will be left on your answering machine or voice mail.
5) Your chiropractor and members of the practice staff may call you by your first and last name at any time and location while in the clinic.
6) Your chiropractor and members of the practice staff may have advert conversation with you in the reception area, hallway, treatment rooms, therapy rooms, or any other location inside of the clinic.
7) Your chiropractor and members of the practice staff may need to use your name and address on a postcard to mail to you: a Birthday card which allows you to receive a free spinal or extremity adjustment, Thank You grams, Holiday greeting cards, Thank You referral cards, and a Recall card reminding you of our commitment to your health.
8) Your chiropractor and member of the practice staff may state your name and address on a Thank You postcard sent to the patient or patients who referred you to our office.
9) Your chiropractor and member of the practice staff may use your name on an internal “Thank You” board.
10) Your chiropractor and member of the practice staff may use your name on an internal “Patient Orientation Class” board as a reminder to you of our class.
11) Your chiropractor and member of the practice staff may use your name on an internal board listing any specific classes offered in our clinic.
12) Your chiropractor and member of the practice staff may use your name in advertising of any kind.
13) Your chiropractor and member of the practice staff may use your name in any type of testimonial.
14) Your chiropractor and member of the practice staff may use your name and address on mailings with special promotions that our clinic offers.
15) Your chiropractor and member of the practice staff may discuss your case and financial obligation with family members, personal representatives, or other persons responsible for an individual’s care with respect to your location, condition, or death.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, other health related information, or any of the reasons listed in 1-14 of the above list. 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, other health related information, or any of the above reasons at any time.

Marketing

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. We 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 to you. The authorization form you sign for this purpose contains the name of the organization and/or the products and services we are marketing.

You have the right to refuse to give us authorization to contact you for marketing purposes. 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 market products and/or services to you at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

Permitted Disclosures

Under federal law, we are also permitted or required to use or disclose your health information in these following circumstances:

1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.
2) 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.

If you wish to revoke your authorization, please write to us at:

764 E. Glenn Avenue
Auburn, Alabama 36830

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created. We require your request to inspect and/or copy your health information to be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except those required for your treatment, to obtain payment for your services, or to run our practice.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

To contact us

If you would like further information about our privacy policies and practices, please contact:

Auburn Chiropractic Health Clinic, Inc.
Privacy Officer
764 E. Glenn Avenue
Auburn, AL 36830
(334) 501-4691

This notice is effective as of _______________________. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_______________________________________ Patient Name Printed

_______________________ Date

_______________________________________ Patient Signature

_______________________ Authorized Provider Representative

_______________________________________ Personal Representative Printed

_______________________ Personal Representative Signature

____
Description of personal representative's authority to act for the patient

DOUGLAS O. PITT, B.S., D.C.

Auburn Chiropractic Health Clinic, Inc.
Glendean Shopping Center
764 East Glenn Ave.
Auburn, Alabama 36830
Telephone: (334) 501-4691
Fax: (334) 501-4693

Your insurance is a contract between you and the insurance company. There is an infinite number of ways that your insurance coverage may or may not be extended. We have no control over the business practices of your insurer. We are a third party with your insurer, to whom they have no obligation. We make no guarantee of what coverage your insurer will actually extend. You remain responsible to Auburn Chiropractic Health Clinic for all charges incurred for services provided by or through us. As a courtesy to you, we will file claims to Blue Cross/Blue Shield and/or Medicare for services rendered by Auburn Chiropractic Health Clinic. You must meet your deductible and co-pays as charges are incurred. It is our office policy not to carry a balance over $75.00 on the books for any individual. All charges denied by your insurance company become due and payable immediately.

Please sign as proof that you have read and understand the above.

____ ______________________
Signature of Patient or Responsible Party Date

____ ______________________
Signature of Witness Date

I have been made aware that due to the number of calls that Blue Cross/Blue Shield receives daily, Auburn Chiropractic Health Clinic has not been able to get through to a representative to verify my insurance benefits. I understand that I am responsible for today's charges, my deductible, and/or co-pay and I will be asked to pay this amount in full according to my insurance benefits. I also understand that Dr. Pitt will not treat me according to my insurance plan but rather according to my needs as an individual.

Please sign as proof that you have read and understand the above.

____ ______________________
Signature of Patient or Responsible Party Date

____ ______________________
Signature of Witness Date

HEALTH QUESTIONNAIRE

Name:___________________________________ Date:____________________

- List all of your current health problems:

- List any other doctors seen and list treatment received and results obtained:

- Have you been to another chiropractor? If yes, please give name and approximate date of last adjustment:

- List all surgeries you have had, along with surgery dates:

- List any medications you are now taking:

- Have you ever been in an automobile accident? If yes, when?

- Have you ever been in an industrial injury or any other injury for which you received treatment? If yes, when?

♦ Please check the conditions you currently have or have had:

❒ AIDS or HIV+	❒ Epilepsy	❒ Polio
❒ Anemia	❒ Hypoglycemia	❒ Rheumatic Fever
❒ Arthritis	❒ Multiple Sclerosis	❒ Tuberculosis
❒ Cancer	❒ Parkinson's Disease	❒ Venereal Disease

FAMILY HISTORY

Family member	Age	Health problems or cause of death
Mother:		
Father:		
Mother's mother:		
Mother's father:		
Father's mother:		
Father's father:		
Brothers:		
Sisters:		
Children:		

HEALTH REVIEW

Name:___________________________________

Please check all symptoms that apply to you.

SKIN /HAIR /NAILS

❒ Eczema
❒ Itchy skin
❒ Rough, scaly skin
❒ Dry skin
❒ Oily skin
❒ Psoriasis
❒ Pale skin
❒ Yellow skin
❒ Bruise easily
❒ Dry scalp
❒ Oily scalp
❒ Baldness
❒ Paper-thin nails
❒ Nail biting

EYES

❒ Blurring of vision
❒ Double vision
❒ Eyes fatigue easily
❒ Excessive tearing
❒ Lack of tearing
❒ Light bothers eyes
❒ Excessive itching of eyes
❒ Pain in eyeball

EARS

❒ Loss of hearing
❒ Pain in ears
❒ Discharge from ears
❒ Vertigo
❒ Ringing in ears

NOSE /NASOPHARYNX /SINUSES

❒ Unusual nasal discharge
❒ Nose bleeds
❒ Pressure over eyes
❒ Pressure under eyes
❒ Obstruction of nose
❒ Frequent colds
❒ Sinusitis
❒ Nasal allergies
❒ Loss of sense of smell
❒ Any trauma to nose

MOUTH AND THROAT

❒ Pain in mouth
❒ Pain in throat
❒ Bleeding gums
❒ Cavities in teeth
❒ Abscessed teeth
❒ Dentures
❒ Difficulty swallowing
❒ Changes in voice

RESPIRATORY

❒ Shortness of breath
❒ Can't breathe while lying down
❒ Can't sleep while lying down
❒ Dry cough
❒ Productive cough
❒ Coughing up blood
❒ Wheezing

GASTROINTESTINAL

❒ Poor appetite
❒ Constant nibbling
❒ Difficulty in swallowing
❒ Indigestion
❒ Can't eat certain foods
❒ Nausea and vomiting
❒ Jaundice
❒ Abdominal pain
❒ Change in bowel habits
❒ Diarrhea
❒ Constipation
❒ Hemorrhoids

GENITOURINARY

Urination is: ❒ frequent
❒ normal
❒ infrequent

Amount is: ❒ high
❒ normal
❒ low

❒ Have to urinate during the night
❒ Abnormal intense desire to urinate
❒ Difficulty starting urination
❒ Decreased output
❒ Pain upon urinating
❒ Dribbling
❒ Blood in urine
❒ Cloudy urine
❒ Lack of bladder control
❒ Abdominal pain

VENEREAL DISEASE

❒ AIDS
❒ Syphilis
❒ Gonorrhea
❒ Other_______________________

SOCIAL HISTORY

❒ Smoking
❒ Other tobacco use
❒ Alcohol use
❒ Drink coffee or tea

Diet is: ❒ balanced
❒ not balanced

Rest is: ❒ sufficient
❒ not sufficient

Recreation is: ❒ sufficient
❒ not sufficient

My family stress is:
❒ severe
❒ moderate
❒ minimal
❒ none

How do you like your work?:
❒ I like it very much.
❒ It's okay.
❒ I hate it.

My job stress is:
❒ severe
❒ moderate
❒ minimal
❒ none

❒ Nervousness
❒ Irritability
❒ Fatigue
❒ Depression
❒ Generally feel run-down
❒ Crave sweets
❒ Crave salt

WOMEN ONLY

❒ Painful menstrual periods
❒ Spotting
❒ Vaginal discharge
❒ Premenstrual symptoms
❒ Irregular periods
❒ Lumps in breast

Number of pregnancies:________

Number of deliveries:__________

Name___________________________________

Please check all symptoms that apply to you.

CARDIOVASCULAR

- ❒ General swelling
- ❒ Swelling in legs
- ❒ Swelling in face
- ❒ Swelling around eyes
- ❒ Chest pain
- ❒ Pounding heartbeat
- ❒ Heart "jumps"
- ❒ Rapid heartbeat
- ❒ Blue or purple skin
- ❒ Blue or purple nail beds
- ❒ Fainting
- ❒ Hypertension

VERTEBROBASILAR

- ❒ Double vision
- ❒ Loss of coordination
- ❒ Irregular muscle movement
- ❒ Ringing in ears
- ❒ Heart attack
- ❒ High blood pressure
- ❒ Irregular heartbeat
- ❒ Hardening of the arteries
- ❒ Areas of muscle weakness
- ❒ Dizziness with nausea
- ❒ Dizziness without nausea
- ❒ Blurred vision
- ❒ Fainting spells
- ❒ Stroke
- ❒ Diabetes
- ❒ Pain over the heart
- ❒ Cold hands and/or feet
- ❒ Areas of numbness
- ❒ Arthritis of the neck
- ❒ Previous neck or head injury
- ❒ Loss of memory
- ❒ Inability to form words or talk plainly
- ❒ Periods of blindness in one eye
- ❒ Areas of abnormal sensations, such as burning, etc.
- ❒ Areas of numbness
- ❒ Blood vessel disease (phlebitis, etc.)
- ❒ Check if you smoke
- ❒ Check if any family members have had a stroke
- ❒ Check if you are taking birth control pills

MUSCULOSKELETAL SYSTEM

HEAD

- ❒ Unusually frequent headaches
- ❒ Unusually severe headaches
- ❒ Head feels heavy
- ❒ Vertigo
- ❒ Light-headedness
- ❒ Loss of smell
- ❒ Loss of taste
- ❒ Loss of balance
- ❒ Dizziness

NECK

- ❒ Pain in neck
- ❒ Neck pain with movement
- ❒ Swelling in neck
- ❒ Stiff neck
- ❒ Pinched nerve in neck
- ❒ Neck feels out of place
- ❒ Muscle spasms in neck
- ❒ Grinding sounds in neck
- ❒ Popping sounds in neck
- ❒ Limited neck movement

SHOULDERS

- ❒ Pain in shoulder - right / left
- ❒ Pain across shoulders
- ❒ Tension in shoulders
- ❒ Muscle spasms in shoulders
- ❒ Can't raise arm above shoulder level
- ❒ Can't raise arm over head

ARMS AND HANDS

- ❒ Pain in upper arm
- ❒ Pain in forearm
- ❒ Pain in hands
- ❒ Pain in fingers

Sensation of pins & needles:

- ❒ in arms
- ❒ in hands
- ❒ in fingers

- ❒ Fingers go to sleep
- ❒ Hands cold
- ❒ Swollen joints in fingers
- ❒ Sore joints in fingers
- ❒ Loss of grip strength

MID BACK

- ❒ Mid-back pain
- ❒ Pain between shoulder blades
- ❒ Sharp stabbing pain
- ❒ Dull ache
- ❒ Pain from front to back
- ❒ Pain over kidney area
- ❒ Muscle spasms in mid back

LOW BACK

- ❒ Low back pain
- ❒ Low back feels out of place
- ❒ Muscle spasms in low back

HIPS, LEGS, AND FEET

- ❒ Pain in buttocks
- ❒ Pain down leg
- ❒ Knee pain
- ❒ Leg cramps
- ❒ Pins & needles in legs
- ❒ Numbness in leg
- ❒ Numbness in toes
- ❒ Cold feet
- ❒ Swollen ankles
- ❒ Swollen feet

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. 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. 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.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

____
Printed Name

____
Signature

____
Date

____
Authorized Provider Representative

____
Date