
CAVE SPRINGS CHIROPRACTIC
PATIENT INFORMATION

Patient First Name: _____ M.I.: _____ Last Name: _____
Address: _____ City: _____
State: _____ Zip: _____ E-Mail: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____ Sex: M / F
Marital Status: M S D W Birth Date: _____ Social Security #: _____
Employer: _____

Spouse's First Name: _____ M.I.: _____ Last Name: _____
Spouse's Social Security: _____ Birth Date: _____
Employer's Name: _____

CURRENT HEALTH CONDITION

Purpose of this appointment _____
Other Doctors seen for this condition? _____ Who? _____
Type of Treatment: _____ Results? _____
When did this condition begin? _____ Has this condition Occurred before? Y / N
Is your problem related to an injury?
 Yes No Car Accident Slip/Fall Work Related Other
If other, please describe: _____
Drugs you now take: _____
Do you wear a shoe lift? Y / N
Do you suffer from any condition other than that which you are now consulting us?

PAST HEALTH HISTORY

Please check and describe:
 Major Surgery Appendectomy Tonsillectomy Gall Bladder Hernia
 Back Surgery Broken Bones Other
Major Accident or Falls: _____
Hospitalization (Other than above): _____

HOW WERE YOU REFERRED?

How were you referred?
 Newspaper Insurance Company Health Presentation Yellow Pages Other
 Referred by: _____

**IF THIS IS DUE TO AN AUTOMOBILE ACCIDENT OR A WORKERS COMPENSATION CLAIM,
PLEASE LET THE FRONT DESK PERSON KNOW THAT! THANKS**

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PATIENT CONFIDENTIAL HEALTH HISTORY

The items below may relate to your current condition. In the space in front of each item, enter (Y) if you have **EVER HAD** the problem, or enter (N) if you have **NEVER HAD** the problem. *(Please put the year of problem.)*

GENERAL		RESPIRATORY		MUSCULOSKELETAL	
1	Fever	45	Difficulty in Breathing	87	Neck Stiffness/Pain
2	Chills	46	Chronic Cough	88	Pain Between Shoulders
3	Night Sweats	47	Spitting Phlegm	89	Low Back Pain
4	Loss of Sleep	48	Spitting Blood	90	Swollen Joints
5	Fatigue	49	Wheezing/Asthma	91	Painful Joints
6	Nervousness	50	Pneumonia	92	Muscle Aches/Soreness
7	Weight Loss or Gain	51	Tuberculosis	93	Spinal Curvature
8	Allergies			94	Arthritis
9	Bleeding Problems	CARDIOVASCULAR		WOMEN ONLY	
10	Anemia	52	Irregular Heartbeat	95	Painful Periods
11	Diabetes	53	High Blood Pressure	96	Excessive Flow
12	Cancer	54	Pain Over Heart	97	Irregular Cycles
13	Thyroid Disease/Goiter	55	Previous Heart Trouble	98	Vaginal Burning/Itching
14	Alcoholism	56	Ankle Swelling	99	Hot Flashes
15	Drug Abuse	57	Varicose Veins	100	Date Last Period Began:
EAR, EYE, NOSE, THROAT		58	Rheumatic Fever	101	Date of Last Pap Smear:
16	Poor Vision	59	Stroke	EXERCISE	
17	Pain in Eye(s)	GENITOURINARY		102	None
18	Deafness/Difficulty Hearing	60	Frequent Urination	103	1 - 2 times/week
19	Nosebleeds	61	Painful Urination	104	3 - 5 times/week
20	Nose Problems	62	Blood in Urine	105	6 - 7 times/week
21	Sinus Trouble	63	Kidney Disease	HABITS	
22	Dental Problems	64	Urinary Infection	106	Smoking ___# packs - day
23	Hoarseness	65	Inability to Control Urination	107	Drinking
24	Tonsillectomy	66	Difficulty Starting Urine Flow	108	Recreational Drug Use
GASTROINTESTINAL		67	Get Up at Night to Urinate	109	Caffeine
25	Poor Appetite	68	Breast Lump or Pain	FAMILY HISTORY	
26	Poor Digestion	69	Veneral Infection	DO NOT INCLUDE YOURSELF	
27	Difficulty Swallowing	70	Sexual Difficulties	Include information on brothers, sisters parents and grandparents.	
28	Belching or Gas	SKIN		110	Diabetes
29	Frequent Nausea	71	Itching	111	Thyroid Disease/Goiter
30	Vomiting	72	Bruising Easily	112	Tuberculosis
31	Vomiting Blood	73	Change in Mole(s)	113	Kidney Disease
32	Pain over Abdomen	74	Skin Cancer	114	High Blood Pressure
33	Ulcer	75	Scars Location	115	Heart Disease
34	Black or Bloody Stools	NEUROLOGIC		116	Cancer
35	Liver Problems	76	Weakness	117	Muscle, Bone or Nerve Disease
36	Gall Bladder Problems	77	Twitching	118	Lung Disease
37	Jaundice	78	Tremors	119	Ulcers
38	Hernia	79	Headache	120	Arthritis
39	Diarrhea	80	Fainting	121	Seizures/-strokes
40	Constipation	81	Dizziness	MISCELLANEOUS	
41	Hemorrhoids	82	Convulsions	_____	
42	Appendicitis	83	Epilepsy/Seizures	_____	
MEN ONLY		84	Numbing/Tingling	_____	
43	Testicular Swelling/Pain	85	Arm/Leg Pain	_____	
44	Prostate Problems	86	Mental Disorder	_____	

CAVE SPRINGS CHIROPRACTIC

DR. TERRY A. SURTIN

4127 MEXICO ROAD ST. PETERS, MO 63376

(636) 441-5700 FAX (636) 441-7784

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Cave Springs Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Cave Springs Chiropractic to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain the copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Cave Springs Chiropractic – Dr. Surtin has the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Name of Patient

Date