Dr. Martin Schmaltz - Chiropractic Physician
7161 N Lindbergh Blvd - Hazelwood MO 63042 - (314) 731- 4383

Patient Name _____ Date _____

Confidential Patient Health Record

Personal Information

Title: [ ] Mr. [ ] Mrs. [ ] Ms.

Last: _____ First: _____ Middle: _____

Suffix: [ ] Jr. [ ] Sr. [ ] II [ ] III Birth Date: ____/___/_____ Age:_____ Sex: Male / Female

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext_____

Home Phone: (_____) _____-_____ Fax #: (_____) _____-_____ Ext _____

Email Address:_____ Social Security # _____

Emergency Contact

Last: _____ First: _____ Middle: _____

Relationship: [ ] Spouse [ ] Relative [ ] Friend [ ] Other _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext_____

Home Phone: (_____) _____-_____

Employment Information

Business Name:_____

Phone: (_____) _____-_____ Fax #: (_____) _____-_____ Ext _____

Employer's Email Address:_____

Occupation/Job Title:_____ Job Description: _____

Patient Name _____ Date _____

Current Health Condition

Unwanted Condition (Why are you here today?)_____

_____

When did this condition BEGIN? _____/_____/_____

Has it occurred before? [ ] Yes [ ] No When?_____

Is the condition: [ ] Auto Related [ ] Job Related [ ] Home Injury

[ ] Slip or Fall [ ] Lifting [ ] Slept Wrong [ ] Unknown [ ] Other

Explain:_____

_____

Date of Accident: ____/____/_____ Time of Accident: _____

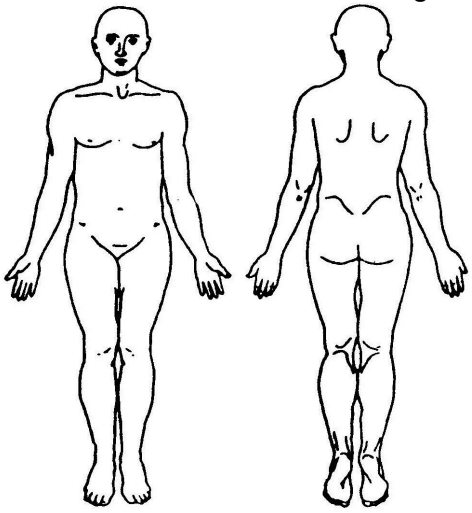
Condition/Pain STARTED on what date: _____

INDICATE YOUR PAIN LEVELS BELOW FOR EACH INJURED AREA

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Use the letters below to indicate the TYPE and LOCATION of your sensations right now.

Key: A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing



0 -1: NO PAIN- to just barely noticeable.
2 - 3: Pain is present, but you may have to stop and think about it to really tell it is there and not gone. You feel fairly comfortable.
4 - 5: You now notice your pain perhaps at rest or during activity. It may interfere with your activities.
6 - 7: Your pain is distracting you, you may be able to focus on something else rather than the pain for only short periods of time. You may be gritting your teeth or holding your breath to carry out activities.
8 -9: Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it. It is difficult to think of anything else but your pain. You may be uncomfortable during rest or quiet times.
10: Your pain is now the worst you can imagine, though it is not necessary for you to be "crying" at this level

---

REVIEW OF SYSTEMS - Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional:	[ ] I DENY having or have had any of the symptoms or problems listed below.		
[ ] chills	[ ] fatigue	[ ] night sweats	[ ] weight loss
[ ] daytime drowsiness	[ ] fever	[ ] weight gain	

Eye/Vision:	[ ] I DENY having or have had any of the symptoms or problems listed below.		
[ ] blindness	[ ] change in vision	[ ] field cuts	[ ] photo phobia
[ ] blurred vision	[ ] double vision	[ ] glaucoma	[ ] tearing
[ ] cataracts	[ ] eye pain	[ ] itching	[ ] wear glasses/contacts

Ear, Nose & Throat:	[ ] I DENY having or have had any of the symptoms or problems listed below.			
[ ] bleeding	[ ] ear drainage	[ ] hearing loss	[ ] nosebleeds	[ ] sore throat
[ ] dentures	[ ] ear pain	[ ] history of head injury	[ ] postnasal drip	[ ] ringing in ears
[ ] difficulty swallow	[ ] fainting	[ ] hoarseness	[ ] runny nose	[ ] TMJ problems
[ ] discharge	[ ] frequent sore throat	[ ] loss of smell	[ ] sinus infection	[ ] headaches
[ ] dizziness	[ ] snoring	[ ] nasal congestion		

Respiration:	[ ] I DENY having or have had any of the symptoms or problems listed below.		
[ ] asthma	[ ] coughing up blood	[ ] sputum production	[ ] cough
[ ] shortness of breath	[ ] wheezing		

Patient Name _____ Date _____

Cardiovascular: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] angina (chest pain)
[ ] chest pain
[ ] claudications (leg pain/ache)
[ ] heart murmur
[ ] heart problems
[ ] varicose veins
[ ] low blood pressure
[ ] difficulty breathing lying down
[ ] palpitations
[ ] wake up at night w/shortness breath
[ ] shortness of breath w/exertion
[ ] swelling of legs
[ ] ulcers

Gastrointestinal: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] abdominal pain
[ ] belching
[ ] black - tarry stool
[ ] constipation
[ ] dizziness
[ ] diarrhea
[ ] difficulty swallowing
[ ] heartburn
[ ] hemorrhoids
[ ] snoring
[ ] indigestion
[ ] jaundice
[ ] nausea
[ ] rectal bleeding
[ ] nasal congestion
[ ] abnormal stool caliber
[ ] abnormal stool color
[ ] abnormal stool consistency
[ ] vomiting blood
[ ] vomiting

Female: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] birth control
[ ] hormone therapy
[ ] pregnancy
[ ] burning urination
[ ] frequent urination
[ ] urine retention
[ ] vaginal bleeding
[ ] irregular menstruation
[ ] cramps
[ ] vaginal discharge
[ ] breast lumps/pain

Male: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] burning urination
[ ] erectile dysfunction
[ ] frequent urination
[ ] hesitancy/dribbling
[ ] prostate problems
[ ] urine retention

Endocrine: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] cold intolerance
[ ] diabetes
[ ] excessive appetite
[ ] excessive hunger
[ ] excessive thirst
[ ] goiter
[ ] abnormal frequency of urination
[ ] hair loss
[ ] heat intolerance
[ ] unusual hair growth
[ ] voice changes

Skin: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] changes in nail texture
[ ] changes in skin color
[ ] hair growth
[ ] hair loss
[ ] hives
[ ] history of skin disorder
[ ] itching
[ ] paresthesias
[ ] rash
[ ] skin lesion/ulcers
[ ] varicosities

Nervous System: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] dizziness
[ ] facial weakness
[ ] headache
[ ] limb weakness
[ ] loss of consciousness
[ ] loss of memory
[ ] numbness
[ ] seizures
[ ] sleep disturbance
[ ] slurred speech
[ ] stress
[ ] strokes
[ ] tremor
[ ] unsteady gait
[ ] loss of balance

Psychologic: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] anhedonia
[ ] anxiety
[ ] loss/change appetite
[ ] behavioral change
[ ] confusion
[ ] convulsion
[ ] depression
[ ] loss of consciousness
[ ] memory loss
[ ] insomnia
[ ] bi-polar disorder
[ ] mood changes

Allergy: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] anaphylaxis
[ ] food intolerance
[ ] itching
[ ] acute nasal congestion
[ ] chronic nasal congestion
[ ] rash
[ ] sneezing

Hematologic: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] anemia
[ ] bleeding
[ ] blood clotting
[ ] blood transfusion
[ ] bruising easily
[ ] fatigue
[ ] lymph node swelling

Patient Name _____ Date _____

PAST HEALTH HISTORY - Fill out carefully as these problems can affect your overall course of care.

Previous care for this SAME CONDITION [ ] I have not previously seen a doctor for this condition. OR FILL in the information BELOW

Have you seen other doctors for THIS CONDITION? [ ] Yes [ ] No If yes, when? _____/_____/_____

Dr.'s Name: _____ Type of treatment: _____

Was it beneficial in resolving condition? [ ] Yes [ ] No Explain: _____

_____

Previous Chiropractic Care: [ ] I have not previously seen a chiropractor OR Fill in information BELOW

Dr.'s Name: _____ Location: _____ Date of last visit: _____

Current Medications: List ANY/ALL medications you are CURRENTLY TAKING. Please be specific

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illnesses: LIST all health conditions. CIRCLE ALL CURRENT conditions

[ ] ADD	[ ] chicken pox	[ ] headaches	[ ] scoliosis
[ ] dermatitis	[ ] crohn's/colitis	[ ] hepatitis	[ ] seizure disorder
[ ] allergies/hay fever	[ ] depression	[ ] HIV	[ ] sickle cell anemia
[ ] anemia	[ ] diabetes	[ ] measles	[ ] spina bifida
[ ] asthma	[ ] ear infections	[ ] mumps	[ ] other
[ ] bedwetting	[ ] fetal drug exposure	[ ] psoriasis	
[ ] cerebral palsy	[ ] food allergies (list below)	[ ] rash	

Adult Illnesses: LIST all health conditions. CIRCLE ALL CURRENT conditions

[ ] ADD	[ ] cystic kidney disease	[ ] hypertension	[ ] psychiatric problem
[ ] Alzheimer's	[ ] depression	[ ] influenza pneumonia	[ ] scoliosis
[ ] anemia	[ ] diabetes (insulin dep)	[ ] liver disease	[ ] seizures
[ ] arthritis	[ ] diabetes (non insulin)	[ ] lung disease	[ ] shingles
[ ] asthma	[ ] eczema	[ ] lupus erythema (discoid)	[ ] past similar conditions
[ ] cancer	[ ] emphysema	[ ] lupus erythema (systemic)	[ ] STD's
[ ] cerebral palsy	[ ] eye problems	[ ] multiple sclerosis	[ ] suicide attempt
[ ] chicken pox	[ ] fibromyalgia	[ ] Parkinson's disease	[ ] thyroid problem
[ ] crohn's/colitis	[ ] heart disease	[ ] unspecified pleural effusion	[ ] vertigo
[ ] CRPS (RSD)	[ ] hepatitis	[ ] pneumonia	[ ] other:
[ ] CVA (stroke)	[ ] HIV	[ ] psoriasis	

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? [ ] yes [ ] no

Patient Name _____ Date _____

Surgery (ies): List all surgical procedures. Write the DATE of the procedure immediately afterward

[ ] angioplasty	[ ] cosmetic	[ ] hysterectomy	[ ] pacemaker insertion
[ ] appendectomy	[ ] D & C	[ ] joint reconstruction	[ ] rotator cuff
[ ] caesarian section	[ ] dental surgery	[ ] joint replacement	[ ] spinal fusion
[ ] cardiac catheterization	[ ] gall bladder	[ ] knee repair	[ ] tonsillectomy
[ ] carpal tunnel repair	[ ] hemorrhoidectomy	[ ] laminectomy	[ ] other
[ ] coronary artery bypass	[ ] hernia repair	[ ] mastectomy	

Injury (ies): List all injuries. Write the DATE of the procedure immediately afterward

[ ] back injury	[ ] head injury (loss consciousness)	[ ] motor vehicle accident
[ ] broken bones	[ ] head injury (no loss consciousness)	[ ] soft tissue injury (mild)
[ ] disability (ies)	[ ] industrial accident	[ ] soft tissue injury (moderate)
[ ] fall (severe)	[ ] joint injury	[ ] soft tissue injury (severe)
[ ] fracture	[ ] laceration (severe)	[ ] other

Family History: Mark all that apply below. List specific conditions past or present after has/had

general family	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
father	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
mother	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
paternal grandfather	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
paternal grandmother	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
maternal grandfather	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
maternal grandmother	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
son (s)	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
daughters (s)	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
brother (s)	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
sister (s)	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____

Insurance Information:

Who is responsible for your bill? YOU and ..... (mark appropriate box (es)) [ ] Myself only [ ] Spouse

[ ] Worker's Comp [ ] Auto Insurance [ ] Medicare [ ] Medicate [ ] Other (be specific) _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holders Date of Birth: _____/_____/_____ Primary Care Physician: _____

Workers Compensation Injury / Auto / Personal

Have you filed an injury report with your employer ? [ ] Yes [ ] No Date: _____/_____/_____ Time: _____

Carrier: _____ Policy # _____

Carriers Phone #: (_____) _____ - _____ Adjuster: _____

Claim #: _____ Attorney: _____

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Dr. Martin Schmaltz, D.C.
7161 North Lindbergh Blvd., Hazelwood MO 63042
p 314.731.4383, f 314.731.4204

Patient: _____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPPA) is available here: http;//ww.cms.hhs.gove/SecurityStandards/Downloads/securityproposedrule.pdf.

1. The patient understands and agrees to allow this office to use their PHI for purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) name by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patient have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment & Informed Consent

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein.

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, dislocation and sprains. Serious complications after manipulation of the cervical spine are estimated to be 1 in 4 million manipulations or fewer.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all the third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation

The patient accepts full financial responsibility for services by this practice.

Initial _____

Patient's Signature: _____ **Date:** _____