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

Personal Information					
Last:		First:		Middle: _	
Birth Date://	_ Age: Sex:	Male / Female	Social S	ecurity #	
Address:					Apt #
City:		State:		Zip:	
Cell Phone: ()		Second Phone: (_)		
Email Address:					
Legal Guardian Information	n - if patient is a mind	or (under 18)			
First Name:	Last:			Relationship:	
Address (if different from all	oove):				
City:		State:		Zip:	
Cell Phone: ()		Second Phone: ()	<u>-</u>	
Email Address:					
Emergency Contact					
Last:		First:		Middle:	
Relationship: [] Spouse []					
Cell Phone: ()					
Employment Information		<u> </u>	•		
Business Name:					
Job Activities:					
Adult Illnesses: Ch	HECK all health cond	litions. CIRCLE IF IT IS	CURREN	Т	
[] arthritis [] cancer [] diabetes [] fibromyalgia	[] heart disease [] HIV [] high blood press [] liver disease	[] lung probler [] lupus sure [] multiple scle [] Other		[] Parkinson [] seizures [] strokes	's disease

Patient Name	Date
Current Health Condition	
Unwanted Condition (Why are you here today?)	Use the letters below to indicate the TYPE and LOCATION of your sensations right now.
When did this condition BEGIN?/	Key: A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing
Has it occurred before? [] Yes [] No When?	
Is the condition: [] Auto Injury [] Job Injury [] Home Injury	
[] Slip or Fall [] Lifting [] Slept Wrong [] Unknown [] Other	
Explain:	
Date of Accident:/ Time of Accident:) 1/2 () 3/2 (
INDICATE YOUR PAIN LEVELS BELOW FOR EACH INJURED AREA	$(\ \Upsilon)$
(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain) When is the condition worse? [] when first get up [] morning	
0 -1: NO PAIN- to just barely noticeable 2 - 3: MILD - Pain is present but does not limit your activities 4 - 5: MODERATE – You can do most activities with rest periods 6 - 7: SEVERE – Unable to do SOME activities because of pain 8 -9: EXTREME- Unable to do MOST activities because of pain 10: DISABLING – Unable to do ANY activities: including putting on clothes, bathi	ng, cooking, driving, almost any movement
[] mid-day [] evening [] at night	
What activities make the condition worse?	
Are you experiencing any other symptoms or health problems? _	
Previous care for this SAME CONDITION [] I have not previously s information BELOW	een a doctor for this condition. OR FILL in the
Have you seen other doctors for THIS CONDITION? [] No [] Ye	s If yes, when?/
Dr.'s Name: Type of	treatment:
Was it beneficial in resolving condition? [] No [] Yes Explain:	
Provious Chiroprostis Care: [1] house not proviously seen a	phiroprostor OD Fill in information DELOW
Previous Chiropractic Care: [] I have not previously seen a c	chiropractor OR Fill in information BELOW
Dr.'s Name: Location:	Date of last visit:

Patient Name		Date	Date			
Current Medications: List	t ANY/ALL medications you	u are CURRENTLY TAK	ING. Please be spe	cific		
Medication	For What Condition?	Medication	For What	t Condition?		
Surgery (ies): List all surgical	al procedures. Write the Da	ATE of the procedure im	mediately afterward			
Surgery	Date	Surgery	Da	ite		
Injury (ies): List all injuries.	Write the DATE of the inju	ry immediately afterward	I			
[] back injury	[] fall (severe)	[joint injury			
[] broken bones	[] head injury	[] head injury [] motor v		vehicle accident		
[] disability (ies) [] industrial accident		cident	other			
Insurance Information:						
Who is responsible for your	bill? YOU and (mark a	ppropriate box (es)) [1	Mvself only [1 Spo	use		
[] Worker's Comp [] Auto						
Personal Health Insurance (
Policy Holder's Name: Gro		Group #:				
Policy Holders Date of Birth	Primary Care F	rimary Care Physician:				
Workers Compensation Inju	ıry / Auto / Personal					
Have you filed an injury repo	ort with your employer ? []	Yes [] No Date:	//Tin	ne:		
Carrier:	Policy # _					
Carriers Phone #: (Adjuster:	Adjuster:			
Claim #:		Attorney:	Attorney:			
Patient Print Name:	Date:	Date:				
Patient's Signature:	Date:	Date:				
Signature of parent or lega	al guardian if patient is u	nder 18 years old.				
Guardian Print Name:		Date: _	Date:			
Guardian's Signature:		Date:	Date:			

Patient:		
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. It high Jews containing the patient is policy before receiving services. A complete copy of the Health Information Portability and Accountability, Act (HIPPA) is available here. It high Jews containing the patient of the purpose of payment. This is includes the named attorney of ecord representing you. This office will limit the release of all PHI to the infimitum necessary to receive payment. This includes the named attorney of ecord representing you. This office will limit the release of all PHI to the infimitum necessary to receive payment. This includes the named attorney of ecord representing you then relate forces at any time and request corrections. The patient may request to know what disclosures have been regulated and submit in writing any further restrictions on the use of their PHI. This office is committed to protection. The patient receives care at this office, regregations. The patient receives care at this office, regregating so 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. 1. This office is committed to protecting your PHI and meeting its HIPAA Obligations: Staff these been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. 2. A patient has the right to file a formation provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office has the right to reduce treatment as deemed necessary by the attending physician. If the patient grants their consent to this office are easily and the patient privacy and		North County Pain Relief Cente 7157 - 7161 North Lindbergh Blvd., Hazelwood MO 63042 ph: 314.731.4383, fax: 314.731.4204
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