

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

**Confidential Patient Health Record**

<b>Patient Information</b>	<b>Date</b>
----------------------------	-------------

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Second Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email Address: \_\_\_\_\_

<b>Legal Guardian Information - if patient is a minor (under 18)</b>
--

First Name: \_\_\_\_\_ Last: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address (if different from above): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Second Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email Address: \_\_\_\_\_

<b>Emergency Contact</b>
--------------------------

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_  
Best Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext \_\_\_\_\_

<b>Employment Information</b>
-------------------------------

Business Name: \_\_\_\_\_  
Describe Job Activities: \_\_\_\_\_

**BEFORE YOUR INJURY, were you experiencing any of the following symptoms/problems?**

back or neck pain  headaches  tingling in arm/hand  tingling in leg/foot  pain in arm or leg

Have you seen a doctor for any of the previous listed health problems?  No  Yes When? \_\_\_\_\_

Dr.'s Name: \_\_\_\_\_ Type of treatment: \_\_\_\_\_

<i>Have you <b>PREVIOUSLY</b> been treated for injuries due to an auto collision?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes When? _____
--

<b>Adult Illnesses:</b> CHECK all health conditions. CIRCLE IF IT IS CURRENT
--

- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> arthritis    | <input type="checkbox"/> heart disease       | <input type="checkbox"/> lung problems      | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> cancer       | <input type="checkbox"/> HIV                 | <input type="checkbox"/> lupus              | <input type="checkbox"/> seizures            |
| <input type="checkbox"/> diabetes     | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> strokes             |
| <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> liver disease       | <input type="checkbox"/> Other _____        | _____  |

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Current Medications: List all medications you are currently taking.

Medication	For What Condition?	Medication	For What Condition?

Surgery (ies): List all surgical procedures.

Surgery	Date	Surgery	Date

Injury (ies): Mark the injuries you have had **BEFORE** this one.

- back injury
- broken bones
- disability (ies)
- fall (severe)
- head injury
- joint injury
- motor vehicle accident
- sports injury
- work accident

Your Auto Insurance OR for the vehicle you were in

Date Of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ Where did accident happen?  Missouri  Illinois  Other \_\_\_\_\_

Did the police come?  No  Yes Did you report the accident/injury to your insurance company?  No  Yes

Name of Policy Holder: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Adjuster: \_\_\_\_\_

Medical Claim #: \_\_\_\_\_ Attorney: \_\_\_\_\_

Person Who Hit You - Insurance

Person's Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Adjuster: \_\_\_\_\_

Medical Claim #: \_\_\_\_\_ Attorney: \_\_\_\_\_

Patient Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of parent or legal guardian if patient is under 18 years old.**

Guardian Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient: \_\_\_\_\_ Age: \_\_\_\_\_

## 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 (HIPAA) is available here: <http://www.cms.hhs.gov/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) named by the patient for the purpose of payment. This includes the named attorney of record representing you. 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. A patient has 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: Patient \_\_\_\_\_ OR Parent or Legal Guardian \_\_\_\_\_

### 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: Patient \_\_\_\_\_ OR Parent or Legal Guardian \_\_\_\_\_

### 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: Patient \_\_\_\_\_ OR Parent or Legal Guardian \_\_\_\_\_

### 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. This includes release of medical & financial information to the patient's attorney.

Initial: Patient \_\_\_\_\_ OR Parent or Legal Guardian \_\_\_\_\_

### Financial Obligation

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

Initial: Patient \_\_\_\_\_ OR Parent or Legal Guardian \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

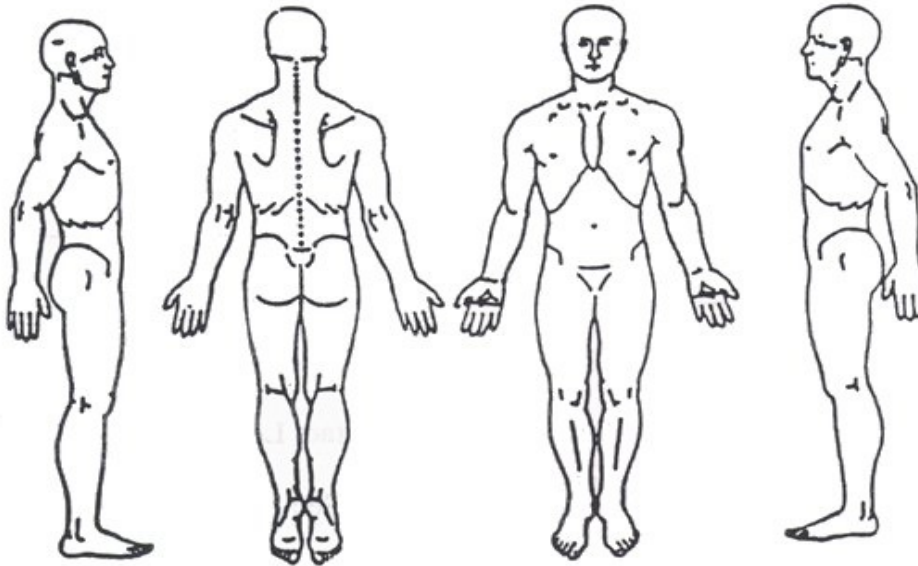
Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**INJURY HISTORY**

Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_

Time of Injury \_\_\_\_\_

Please mark the area of your pain or discomfort:



1. Is your condition currently...  worsening  improving  unchanged?
2. Is your condition worse in the:  Morning  Afternoon  Night  With Activity

Circle any of the following you have experienced since your injury			
Mood swings	Depression	Sensitive to sound	Dizziness
Confusion	Concentration Difficulties	Nausea	Balance problems
Ringing in the ears	Sensitive to light	Vomiting	Blurred Vision

Mood swings	Depression	Sensitive to sound	Dizziness
Confusion	Concentration Difficulties	Nausea	Balance problems
Ringing in the ears	Sensitive to light	Vomiting	Blurred Vision

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Please **use the following scale** to rate the intensity of **each** area injured from 1-10.

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, bathing, cooking, driving, almost any movement.



Circle Where You Hurt	How much of the day do you hurt?	Intensity 1-10	Sharp	Dull	Aching	Throbbing	Shooting	Pins & Needles			
	Occasional On and off Most of day All day										
<i>right side of neck, more on back of neck</i>	<i>Most of day</i>	<b>6</b>	<b>x</b>			<b>x</b>	<b>x</b>				
Headache											
Neck											
Upper Back											
Low Back											
Shoulder Joint											
Elbow											
Wrist											
Hip											
Knee											
Ankle											
Foot											
Other: _____											
Other: _____											

The next form is a request for medical records. If you have sought medical care of any kind for your injury, we need your permission to obtain a copy of those medical records.

Please sign the next form but leave the Doctor/Hospital information blank.

List below the urgent care, hospital(s) and/or doctor(s) that you have seen.

Patient Name: \_\_\_\_\_

Urgent Care: \_\_\_\_\_ Were X-rays taken? Y N

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ When did you go?: \_\_\_\_\_

Hospital: \_\_\_\_\_ Were X-rays taken? Y N

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ When did you go?: \_\_\_\_\_

Doctor: \_\_\_\_\_ Were X-rays taken? Y N

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ When did you go?: \_\_\_\_\_

Doctor: \_\_\_\_\_ Were X-rays taken? Y N

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ When did you go?: \_\_\_\_\_

**Dr. Martin Schmaltz**  
7161 N Lindbergh Blvd, Hazelwood MO 63042  
(314) 731-4383 Fax (314) 731-4204

**REQUEST FOR MEDICAL RECORDS**

Date: \_\_\_\_\_

**REQUESTING FROM:**

\_\_\_\_\_  
**Doctor or Hospital Name**

**RECORDS FAX:** \_\_\_\_\_

\_\_\_\_\_  
**Address**

**RADIOLOGY FAX:** \_\_\_\_\_

\_\_\_\_\_  
**City, State, Zip**

**PATIENT INFORMATION**

\_\_\_\_\_  
**Patient Name** **Age**

\_\_\_\_\_  
**SS#**

\_\_\_\_\_  
**Date Of Birth**



Please send imaging films or disc and  
medical records from \_\_\_\_\_  
**to the present.**

**I authorize the release of my imaging films or disc and medical records to be sent to the requestor:**

**Dr. Martin Schmaltz**  
7161 N Lindbergh Blvd, Hazelwood MO 63042  
(314) 731-4383 Fax (314) 731-4204

This request is valid for 180 days past the date of signature seen below.

\_\_\_\_\_  
**Patient Signature** **Date**

\_\_\_\_\_  
**Parent or Legal Guardian Signature** **Relationship** **Date**

\_\_\_\_\_  
**Parent or Legal Guardian Print Name**