

CONFIDENTIAL PATIENT APPLICATION FOR CARE

Welcome to our Practice! Please complete all questions. Thank you (Please print)

Patient Name: _____ Date: ____/____/____ Account# _____

If patient is considered a minor or is under age 18, parent/legal guardian must sign to accept responsibility and complete form:

Responsible Party Name: _____ Signature _____

Address: _____ Home Phone _____

City: _____ State: _____ Zip: _____ Cell: _____

Date of Birth: ____/____/____ Age: _____ Gender: ☐ Male ☐ Female Marital Status: M W D S

Social Security # _____ - _____ - _____ Spouse's Name: _____

Email: _____ Work Ph: _____

Employer: _____ Employer Address: _____

Emergency Contact: _____ Ph: _____ Cell: _____

Whom may we thank for referring you to our clinic? _____

How many children do you have? ____ Names and Ages? _____

Have they, or any other family members received chiropractic care? Y N If yes, whom? _____

Have you ever had chiropractic care? Y N If yes, when? _____

List your reason(s) for this appointment:

1. _____ How Long? _____

2. _____ How Long? _____

3. _____ How Long? _____

Does the pain spread (radiate)? ☐ 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 sit to stand? ☐ Yes ☐ No If yes, where? _____

Do you have headaches? ☐ Yes ☐ No If yes, check all that apply: ☐ Tension ☐ Throbbing ☐ Sinus ☐ Migraine

Indicate any function below that aggravates, or is aggravated by, your condition: (check all that apply)

☐ Walking ☐ Step Climbing ☐ Driving ☐ Working ☐ Recreation ☐ Bowel Movements
☐ Sinuses ☐ Digestion ☐ Breathing ☐ Hearing ☐ Vision ☐ Smelling ☐ Sleeping ☐ Menstrual

Have you ever suffered from or been diagnosed as having: (Circle Yes or No for each)

Y N Broken or Fractured Bones	Y N Drug Addiction	Y N Ulcers
Y N Osteoarthritis	Y N Seizures/Convulsions	Y N Head Problems
Y N Eating Disorder	Y N Strokes	Y N High/Low Blood Pressure
Y N Circulatory Problems	Y N HIV Positive	Y N Ruptures
Y N Epilepsy	Y N Congenital Disease	Y N Depression
Y N Alcoholism	Y N Cancer	Y N Diabetes
Y N Rheumatoid Arthritis	Y N Gall Bladder	Y N Coughing Blood
Y N Pacemaker	Y N Excessive Bleeding	Y N Tumors

CONFIDENTIAL: Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, i.e. TB, Hepatitis.

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU'VE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain / Stiffness
- ☐ Problems Walking
- ☐ Difficulty Chewing
- ☐ Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM

- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Fainting
- ☐ Convulsion
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urination

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL

- ☐ Difficulty Urinating
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stools

MALE

- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

C V R (Chest Heart Lungs)

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Lung Problems / Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT (Eyes Ears Nose Throat)

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffy Nose

FEMALE

- ☐ Irregular Cycle or Amenorrhea
- ☐ Severe Menstrual Cramps
- ☐ Heavy Bleeding
- ☐ Breast Pain / Lumps
- ☐ Full/Partial Hysterectomy
- ☐ Vaginal Pain / Infections

Date of Last Period: _____

Are you Pregnant? Y N Unsure

FAMILY HISTORY:

The following members have the same or similar problems I have: (Circle any that apply):

Mother Father Sister Brother Spouse Child Other: _____

What are your goals for your health? _____

What brings you through our door today? _____

What are your expectations? _____

How often do you drink alcoholic beverages? _____

Do you smoke? ☐ Yes ☐ No If so, how much? _____

Do you exercise? ☐ Yes ☐ No If so, how often? _____

Do you have any allergies? (Please specify): _____

MEDICATION LIST:

Medication	Vitamins	Rx Strength	Non-Rx Strength	Date Started	Date Ended	Prescribed by:

➡ Any vaccinations or boosters taken in the last 6 months (Specify): _____

Have you received a Covid-19 Vaccination? ☐ Yes ☐ No If yes, how many? _____

Please identify all facilities/providers you've seen, or are currently seeing, for these conditions:

Dr. / Provider / Facility	Problem	Type of Treatment Received	When

Medical Information Release (HIPAA Release)

☐ I authorize Dr. Hannouche to provide treatment for my condition(s) found through examination and/or x-rays related to vertebral subluxation.

☐ I authorize Hannouche Family Chiropractic to contact me via ☐ home ☐ work ☐ cell: _____

If unable to reach me: ☐ leave a detailed message ☐ leave a message requesting a call back

The best time to reach me is during the day between the hours of ____ and ____.

☐ I authorize Hannouche Family Chiropractic to use my name (first name + last initial only) on our Welcome Board.

☐ I authorize the release of information including the diagnosis, records, and examination results rendered to me, and claims information to me, my insurance company if requested, as well as any person listed below:

☐ Spouse _____

☐ Child(ren) _____

☐ Others _____

☐ Release no information without my ☐ written ☐ verbal consent.

FEMALE PATIENTS: VERIFICATION OF NON-PREGNANCY

I, _____, hereby state that to the best of my knowledge I am not pregnant. It is neither suspected nor confirmed at this time.

Patient Signature: _____

CHECK ANY OF THE FOLLOWING SYMPTOMS YOUR FAMILY HAS HAD IN THE PAST 6 MONTHS:

MUSCULOSKELETAL

☐ **Low Back Pain**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Pain Between Shoulders**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Neck Pain**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Arm Pain**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Joint Pain**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Problems Walking**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Clicking Jaw**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

NERVOUS SYSTEM

☐ **Nervous**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Numbness**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Paralysis**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Fainting**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Convulsions**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Cold/Tingling Extremities**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

GASTROINTESTINAL

☐ **Excessive Thirst**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Frequent Nausea**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Vomiting**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Diarrhea**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Constipation**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Liver Problems**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Gall Bladder**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Weight Trouble**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Heartburn**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Colitis**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

GENITO-URINARY

☐ **Bladder Trouble**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

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C V R (Chest Heart Lungs)☐ **Chest Pain**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Shortness of Breath**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Blood Pressure (Hi/Lo)**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Heart Problems**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Lung Problems**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Ankle Swelling**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Stroke**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

MALE / FEMALE☐ **Menstrual Irregularity**

___ Mother
___ Children
___ Siblings
___ Spouse

☐ **Menstrual Cramps**

___ Mother
___ Children
___ Siblings
___ Spouse

☐ **Vaginal**

___ Mother
___ Children
___ Siblings
___ Spouse

☐ **Pain/Infections**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Breast Pain / Lumps**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Prostate/ Sexual Dysfunction**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

EENT (Eyes Ears Nose Throat)☐ **Sore Throat**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Earaches**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Hearing**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Heart Problems**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

GENERAL☐ **Fatigue**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Allergies**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

☐ **Headaches**

___ Mother
___ Father
___ Children
___ Siblings
___ Spouse

OTHER SYMPTOMS:

Signature: _____ Date: _____

Witness: _____ Date: _____

Thank you for putting your trust in Hannouche Family Chiropractic Clinic. You are in good hands.

HIPAA Notice of Privacy Practices

Effective Date:

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

Questions? Contact our Privacy Officer at

Our Obligations

We are required by law to: (1) maintain the privacy of your protected health information (PHI); (2) provide you with this Notice; (3) follow the terms of the current Notice; and (4) notify you promptly if a breach of your unsecured PHI occurs.

How We May Use and Disclose Your Health Information

We may use and disclose your Health Information without written authorization for the following purposes. All other uses require your written authorization, which you may revoke in writing at any time.

Treatment, Payment, and Health Care Operations (TPO).

We may use and disclose your Health Information to provide and coordinate your medical care (e.g., sharing records with a specialist); to bill and collect payment from you, your insurer, or another payer; and to manage our practice and ensure quality care, including evaluating the quality of obstetric or gynecologic services you receive.

Other Permitted Uses and Disclosures.

We may also use or disclose Health Information, to the extent permitted or required by law, for the following purposes:

- Appointment reminders, treatment alternatives, and health-related benefits or services.
- Individuals involved in your care or payment, such as family members, or for disaster relief notification.
- Research, subject to a special approval process and applicable legal protections.
- As required by federal, state, or local law.
- To avert a serious and imminent threat to health or safety.
- To business associates who perform services on our behalf, under written confidentiality agreements.
- Organ and tissue donation organizations.
- Military command authorities or foreign military authorities, if applicable.
- Workers' compensation or similar programs.
- Public health activities (e.g., disease reporting, abuse reporting, product recalls).
- Health oversight agencies for audits, investigations, inspections, and licensure.
- Judicial and administrative proceedings, in response to a court order or lawful process.
- Law enforcement, in response to legal process or as otherwise permitted by law.
- Coroners, medical examiners, and funeral directors.
- National security, intelligence, and protective services for authorized federal officials.
- Correctional institutions or law enforcement, if you are an inmate or in custody.

Uses and Disclosures Requiring Your Written Authorization.

We will not use or disclose your Health Information without your written authorization for: (1) psychotherapy notes; (2) marketing purposes; or (3) any sale of Health Information. You may revoke any such authorization in writing at any time.

Substance Use Disorder (SUD) Records — Additional Protections

If we receive or maintain records related to your treatment, diagnosis, or referral for a substance use disorder, those records are subject to heightened federal protections under 42 CFR Part 2, in addition to HIPAA.

- **Consent required:** Unlike general PHI, SUD Records generally cannot be used or disclosed for treatment, payment, or health care operations without your written consent. You may provide a single written consent covering all future TPO uses and disclosures.
- **Legal proceedings restriction:** SUD Records may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order issued after notice and an opportunity to be heard, as provided in 42 CFR Part 2.
- **No re-disclosure:** Recipients of your SUD Records are prohibited from re-disclosing them unless permitted by federal law or your written consent.
- **Your rights:** You have the same privacy rights for your SUD Records as for other Health Information, including the rights described below.

Your Rights

- **Inspect and copy your records:** You have the right to inspect and copy your medical and billing records (excluding psychotherapy notes) used to make decisions about your care, including the right to receive an electronic copy if records are maintained electronically. Submit a written request to our Privacy Officer.
- **Amend your records:** You may request that we amend incorrect or incomplete Health Information by submitting a written request to our Privacy Officer.
- **Accounting of disclosures:** You may request a list of certain disclosures we have made for purposes other than TPO or where you provided authorization. Submit a written request to our Privacy Officer.
- **Request restrictions:** You may request restrictions on how we use or disclose your Health Information. We are not required to agree — except that if you pay out-of-pocket in full for a service and request we not share that information with your health plan, we must honor that restriction. Submit a written request to our Privacy Officer.
- **Confidential communications:** You may request that we communicate with you in a specific way or at a specific location (e.g., by mail only, or at your work address). Submit a written request to our Privacy Officer.
- **Paper copy of this Notice:** You may request a paper copy of this Notice at any time, even if you agreed to receive it electronically.
- **Breach notification:** You have the right to be notified in writing within 60 days if a breach of your unsecured PHI occurs.

Changes to This Notice

We reserve the right to change this Notice and apply revised terms to all Health Information we hold. A current copy is posted in our office. The effective date appears at the top of this Notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the U.S. Department of Health and Human Services, Office for Civil Rights (www.hhs.gov/ocr/privacy/hipaa/complaints, 1-800-368-1019). You will not be penalized for filing a complaint.

Privacy Officer Contact

Acknowledgment of Receipt

By signing below, I acknowledge receipt of this Notice of Privacy Practices and the opportunity to review its contents.

Patient Signature	Date	Printed Name