



Confidential Patient Information - 4 pages

Your First Name: MI Last Name: Male Date of Birth: Age: Social Security Number:
 Female

Your Marital Status: Single Married Other Number of Children:

Insured First Name: MI Last Name: Male Date of Birth: Age: Social Security Number:
 Female

Your Home Address: City: State: Zip:

Your Preferred Contact Phone Number: Work Phone Number: E-mail Address: Your email will NOT be shared with any 3rd parties, and is used for general office announcements and promotions.

Employer Name: Your Job title/Occupation: Years employed:

Work Address: City: State: Zip:

Health Questionnaire and Overview

If you have ever had a symptom in the past, please list that symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the Present Column.

-KNOWLEDGE OF ANY OF THE FOLLOWING INFORMATION MAY INFLUENCE THE TYPE OF TREATMENT/ THERAPY YOU RECEIVE-

Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	Neck Pain
<input type="radio"/>	<input type="radio"/>	Shoulder Pain (R___ L___)
<input type="radio"/>	<input type="radio"/>	Pain in Upper Arm or Elbow (R___ L___)
<input type="radio"/>	<input type="radio"/>	Hand Pain (R___ L___)
<input type="radio"/>	<input type="radio"/>	Wrist Pain (R___ L___)
<input type="radio"/>	<input type="radio"/>	Upper Back Pain (R___ L___)
<input type="radio"/>	<input type="radio"/>	Lower Back Pain (R___ L___)
<input type="radio"/>	<input type="radio"/>	Pain in Upper Leg or Hip (R___ L___)
<input type="radio"/>	<input type="radio"/>	Pain in Lower Leg or Knee (R___ L___)
<input type="radio"/>	<input type="radio"/>	Pain in Ankle or Foot (R___ L___)
<input type="radio"/>	<input type="radio"/>	Jaw Pain (R___ L___)
<input type="radio"/>	<input type="radio"/>	Headache
<input type="radio"/>	<input type="radio"/>	Swelling, Stiffness of Joint(s)

Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	Fainting, Visual Disturbances, Dizziness
<input type="radio"/>	<input type="radio"/>	Convulsions
<input type="radio"/>	<input type="radio"/>	Muscular Incoordination
<input type="radio"/>	<input type="radio"/>	Tinnitus (Ear Noises)
<input type="radio"/>	<input type="radio"/>	Rapid Heart Beat, Chest Pains (circle)
<input type="radio"/>	<input type="radio"/>	Loss of Appetite, Anorexia (circle)
<input type="radio"/>	<input type="radio"/>	Excessive Thirst
<input type="radio"/>	<input type="radio"/>	Chronic Cough
<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis
<input type="radio"/>	<input type="radio"/>	General Fatigue
<input type="radio"/>	<input type="radio"/>	Depression
<input type="radio"/>	<input type="radio"/>	Painful or Frequent Urination
<input type="radio"/>	<input type="radio"/>	Abdominal Pain
<input type="radio"/>	<input type="radio"/>	Constipation/Irregular bowel habits
<input type="radio"/>	<input type="radio"/>	Heartburn/Indigestion
<input type="radio"/>	<input type="radio"/>	Difficulty in Swallowing
<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema/Rash

Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	High Blood Pressure
<input type="radio"/>	<input type="radio"/>	Aortic Aneurysm
<input type="radio"/>	<input type="radio"/>	Heart Attack (Date: _____)
<input type="radio"/>	<input type="radio"/>	Stroke (Date: _____)
<input type="radio"/>	<input type="radio"/>	Asthma
<input type="radio"/>	<input type="radio"/>	Cancer, Explain _____
<input type="radio"/>	<input type="radio"/>	Prostate Disorders, Explain _____
<input type="radio"/>	<input type="radio"/>	Blood Disorder
<input type="radio"/>	<input type="radio"/>	Emphysema (Chronic Lung Disorders)
<input type="radio"/>	<input type="radio"/>	Arthritis
<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis
<input type="radio"/>	<input type="radio"/>	Diabetes, Type: _____
<input type="radio"/>	<input type="radio"/>	Ulcer
<input type="radio"/>	<input type="radio"/>	Liver/Gallbladder Conditions
<input type="radio"/>	<input type="radio"/>	Hepatitis, Type: _____
<input type="radio"/>	<input type="radio"/>	Bladder Infection
<input type="radio"/>	<input type="radio"/>	Colitis
<input type="radio"/>	<input type="radio"/>	Irritable Colon
<input type="radio"/>	<input type="radio"/>	HIV/AIDS

Yes	No	
<input type="radio"/>	<input type="radio"/>	Do you have permanent Disability Rating? Where: _____
<input type="radio"/>	<input type="radio"/>	Date rating received ___/___/___
<input type="radio"/>	<input type="radio"/>	Rating Percentage _____%

This box for women only:

Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	Menstrual Flow: Irregular, Profuse (circle)
<input type="radio"/>	<input type="radio"/>	Breast O Soreness <input type="radio"/> Lumps
<input type="radio"/>	<input type="radio"/>	Endometriosis
<input type="radio"/>	<input type="radio"/>	PMS
<input type="radio"/>	<input type="radio"/>	Pregnancy, # Births: _____
<input type="radio"/>	<input type="radio"/>	Birth Control Pills, Type: _____
<input type="radio"/>	<input type="radio"/>	Breast implants/Augmentation

Complaints/Symptoms Form

Please carefully list and explain your reason(s) for this visit in the order of importance below.

#1 _____ Date you first noticed: _____

#2 _____ Date you first noticed: _____

#3 _____ Date you first noticed: _____

Problem #1:

Location of pain: Right side Left side Both sides

During what time of the day does this feel worse? _____

Does the pain radiate to different areas? Yes No

If yes, where to: _____

How severe is the pain? (Please make an "X" on the line below)

← no pain _____ severe pain →

During a normal day (awake hours) how frequently do you experience the pain/problem?

0-25 % of the time 25 - 50 % of the time

50 - 75 % of the time 75 - 100 % of the time

What makes the pain worse? _____

What relieves the pain? _____

Please explain **how** this problem happened:

- Developed over time
- Illness
- Injury
- Auto Accident
- Other
- I don't know

Explain:

Problem #2:

Location of pain: Right side Left side Both sides

During what time of the day does this feel worse? _____

Does the pain radiate to different areas? Yes No

If yes, where to: _____

How severe is the pain? (please make an "X" on the line below)

← no pain _____ severe pain →

During a normal day (awake hours) how frequently do you experience the pain/problem?

0-25 % of the time 25 - 50 % of the time

50 - 75 % of the time 75 - 100 % of the time

What makes the pain worse? _____

What relieves the pain? _____

Please explain **how** this problem happened:

- Developed over time
- Illness
- Injury
- Auto Accident
- Other
- I don't know

Explain:

Problem #3:

Location of pain: Right side Left side Both sides

During what time of the day does this feel worse? _____

Does the pain radiate to different areas? Yes No

If yes, where to: _____

How severe is the pain? (please make an "X" on the line below)

← no pain _____ severe pain →

During a normal day (awake hours) how frequently do you experience the pain/problem?

0-25 % of the time 25 - 50 % of the time

50 - 75 % of the time 75 - 100 % of the time

What makes the pain worse? _____

What relieves the pain? _____

Please explain **how** this problem happened:

- Developed over time
- Illness
- Injury
- Auto Accident
- Other
- I don't know

Explain:

Pain/Symptom Drawing

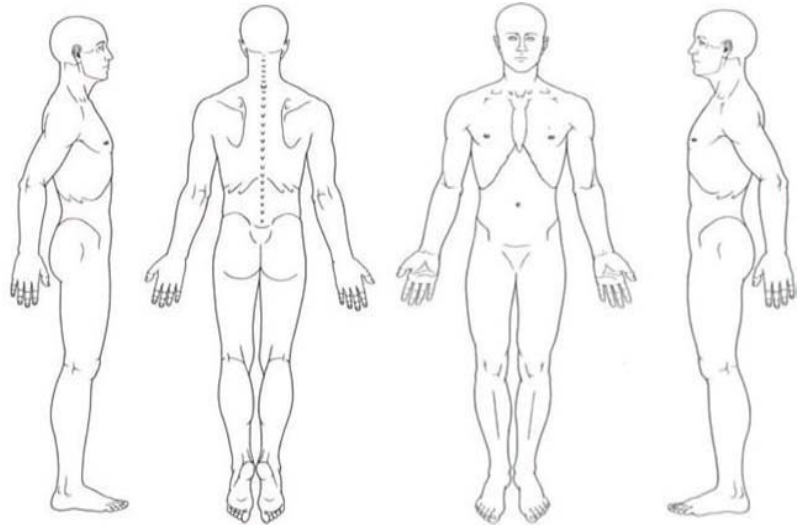
On the picture below, please describe your problems by drawing, circling, and making arrows to the appropriate regions. (e.g. Numbness, pain, weakness, tingling)

Write and draw as much as you need to explain the problem(s).

+++ Sharp and stabbing pain
///// Pins and needles sensation
VVVV Dull or aching pain
oooo Numbness

How are your symptoms changing? Getting better Not changing Getting worse

Please write any additional comments below:



How did you hear about Dr. Johansen? _____

What do you expect to achieve from your visit and/or future visits with Dr. Johansen?

- ◆ I certify that the above information is true and correct to the best of my knowledge. I agree to notify Dr. Johansen immediately whenever I have a change in my health condition.
- ◆ I consent to the release of my confidential medical and patient information in the possession of Dr. Johansen to other health care professionals to whom I am referred and to the insurance company or other entity responsible for payment for all or portion of my care.
- ◆ I authorize Dr. Johansen and her staff to perform any services needed during diagnosis and treatment and I authorize payment of insurance benefits to Dr. Johansen for services rendered.
- ◆ Our policy requires payment for services rendered at the time of visit unless other arrangements have been made with the office manager. I agree to pay 1½ % interest per month on any overdue balances. I understand that I am ultimately liable for all charges for services rendered.
- ◆ Please note that we reserve the right to charge for appointments missed or cancelled without 24 hours advance notice.

Signed (patient or authorized person): _____ Date: _____

PATIENT'S STATEMENT OF PRIVACY RIGHTS

As a patient at Health Logic, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Probability and Accountability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

AS A PATIENT OF THE DOCTORS AT HEALTH LOGIC:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request). You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request). As per allowance by HIPAA there will be a \$15 copy charge.
4. The doctor has a right to deny inclusion of amendments into a patient file; you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request). If the doctor disagrees, s/he shall supply you with written notification of such disagreement.
5. You have the right to specify how access to your health information is restricted and from whom.
6. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
7. All covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable Business Associate Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as we are.
8. No personal health information shall be given out to any entity not related to your treatment and the billing of medical records rendered, without your written authorization.
9. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.

(OVER)

10. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPAA in establishing that standard.
11. You are entitled to choose whether you do not want your name to be seen by others on our recognition board as a new patient or by referring others to our practice. You are also entitled to choose if you do not want a birthday card, newsletter or an e-mail newsletter sent to your house. Please inform the front desk if you would like to exercise this request.
12. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
13. You have the right to contact the Department of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint at, Toll Free: 1-800-696-6775 or E-Mail: www.hhs.gov/ocr.

**PATIENT'S AFFIRMATION OF RECEIPT OF
PATIENT'S STATEMENT OF PRIVACY RIGHTS**

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with the law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

Patient Name (Print Name)

Date

Patient Name (Signature)

(OVER)