

# Old Mill Chiropractic

235 Jungermann Rd., Suite 209, St. Peters, MO 63376  
Phone: (636) 928-7387 Fax (636) 928-1269

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
Marital Status:  Married  Single  Divorced  Separated  Other \_\_\_\_\_  
Number of children: \_\_\_\_\_ Ages of children: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Name of Spouse or Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_  
Your Occupation \_\_\_\_\_ Your Employer: \_\_\_\_\_  
Referred to this Office by:  Friend/Family Member - Name: \_\_\_\_\_  
 Yellow Pages  Mail  Clinic Location  Other \_\_\_\_\_  
Payment for Services will be by:  Cash  Check  Credit Card  Health Insurance  
 Automobile Insurance  Worker's Compensation

Name of Insurance Co.: \_\_\_\_\_ Insured's Name: \_\_\_\_\_  
Insured's Social Security #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
Are you covered by more than one insurance company?  Yes  No Name \_\_\_\_\_

## MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

Please indicate which conditions have been experienced by marking appropriate boxes.

S	M	F	S	M	F	S	M	F			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	dislocated joints	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	epilepsy	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	German measles	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	headaches	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	heart trouble	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	reproductive disorders	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	high blood pressure	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	HIV/ARC	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	kidney disorder	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	bowel control loss	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	menstrual cramps	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	multiple sclerosis	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	muscular dystrophy	venereal disease

Have you been treated by a physician for any health condition in the last year?  Yes  No  
Describe Condition \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_  
Habits: Nicotine/Tobacco usage per day: \_\_\_\_\_ Alcohol/Drinks per week: \_\_\_\_\_ Coffee/Cups per day: \_\_\_\_\_  
Vitamins/Herbs (list all being taken): \_\_\_\_\_  
Exercise: \_\_\_\_\_ None \_\_\_\_\_ Moderate \_\_\_\_\_ Daily

### SURGICAL HISTORY:

1. \_\_\_\_\_ Date: \_\_\_\_\_  
2. \_\_\_\_\_ Date: \_\_\_\_\_  
3. \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had a metal implant?  Yes  No Ever been gunshot?  Yes  No

ACCIDENT HISTORY:  Job  Auto  Other 1. \_\_\_\_\_ Date: \_\_\_\_\_  
 Job  Auto  Other 2. \_\_\_\_\_ Date: \_\_\_\_\_  
 Job  Auto  Other 3. \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:**

Please Rate Your Symptoms (1-10, with 10 being the worst)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

WHEN AND HOW OCCURRED? \_\_\_\_\_

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: \_\_\_\_\_

SYMPTOMS HAVE PERSISTED FOR: \_\_\_ HOUR(S) \_\_\_ DAY(S) \_\_\_ WEEK(S) \_\_\_ MONTH(S) \_\_\_ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? \_\_\_\_\_

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS? \_\_\_\_\_

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO YES WHAT KIND? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS? NO YES WHAT KIND? \_\_\_\_\_

ARE YOU PREGNANT? NO YES DATE OF LAST MENSTRUAL PERIOD \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**

- BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
- LIFTING SNEEZING WALKING LYING DOWN STANDING

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:**

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

**PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:**

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss /confusion
- constipation depression /weeping spells diarrhea dizziness face flushed fainting fatigue fever
- head seems too heavy headaches insomnia light bothers eyes loss of balance loss of smell loss of taste
- low resistance to colds muscle jerking numbness in fingers numbness in toes pins and needles in arms
- pins and needles in legs ringing in ears shortness of breath stiff neck stomach upset

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to Old Mill Chiropractic or Samuel E. Durbin, DC. I authorize Old Mill Chiropractic to release all information necessary to communicate with personal physicians and other healthcare providers and insurance companies and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

The patient understands and agrees to allow Old Mill Chiropractic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Date Signed: \_\_\_\_\_ Signature: \_\_\_\_\_

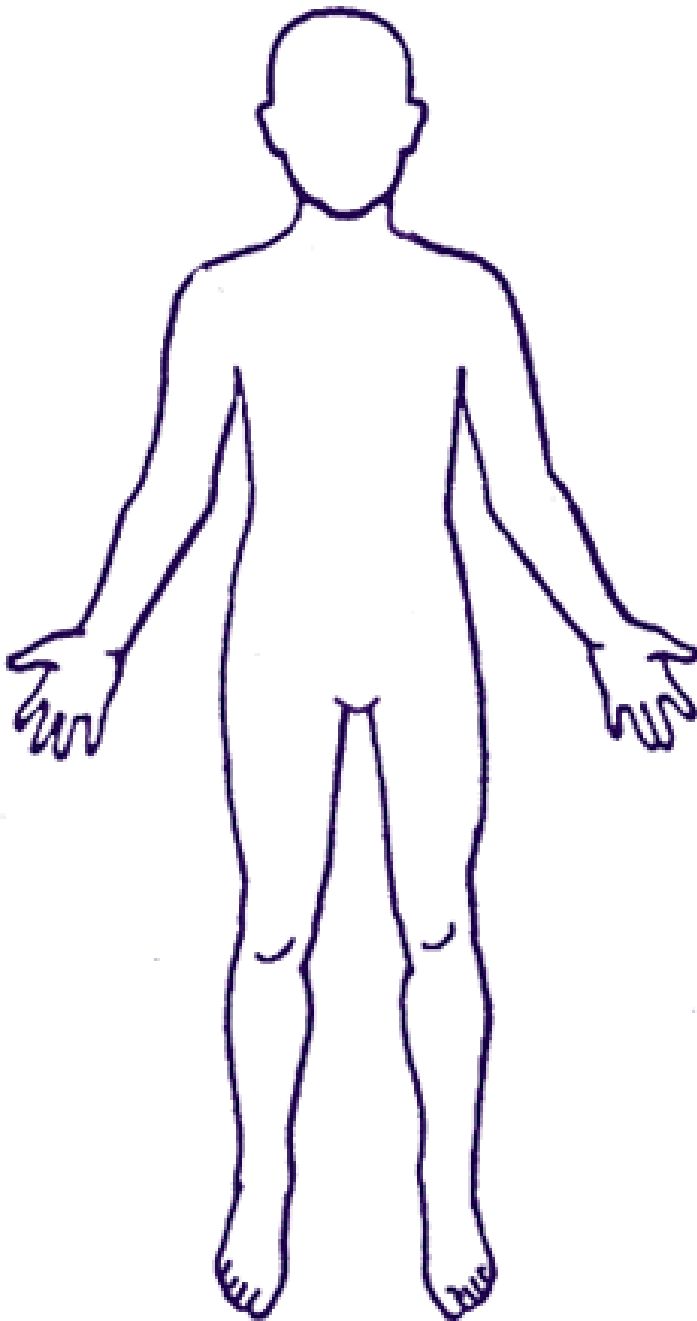
Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

These are front and back views of the human body. Please use a highlighter or marker and color anywhere you are experiencing pain, tingling, numbness, or having any problems with.

Front

Right

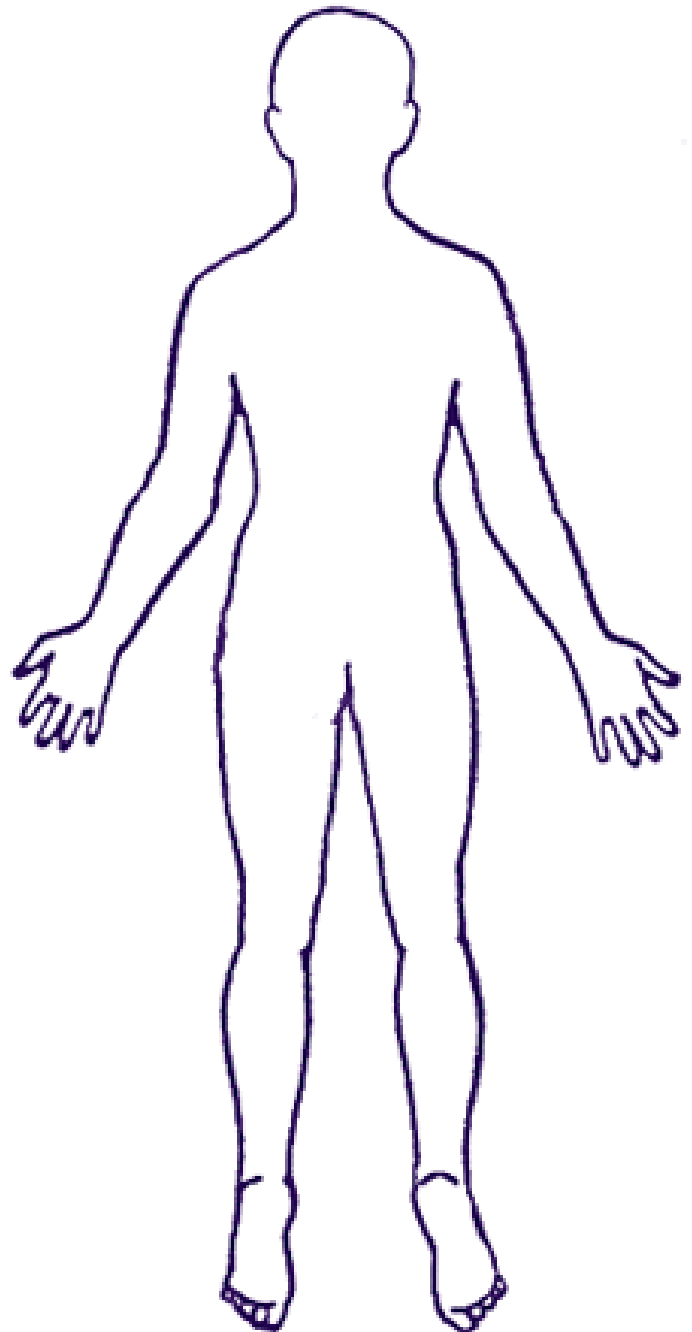
Left



Back

Left

Right



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## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Old Mill Chiropractic to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Old Mill Chiropractic to submit requested **PHI** to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all **PHI** to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own 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**. Old Mill Chiropractic is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient at Old Mill Chiropractic.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures at Old Mill Chiropractic. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Dr. Samuel Durbin, D. C. has the right to refuse to give care.
8. The patient agrees that Old Mill Chiropractic can use **PHI** for in house projects (referral board, patient of the month, newsletter, etc....).

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Patient Signature

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Date

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Print Name of Patient

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**INFORMED CONSENT FOR CHIROPRACTIC CARE**

I hereby request and consent to the performance of chiropractic adjustments and chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays on me (or on the patient named below, for whom I legally responsible) by the doctor, Dr. Samuel Durbin, D.C. or his associates, affiliated with Old Mill Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, dislocations and sprains. I do not expect Dr. Durbin to be able to anticipate and explain all risks and complications. I wish to rely on Dr. Durbin to exercise judgment during the course of the procedure which Dr. Durbin feels at the time, based on the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the Dr. Durbin or his associates, affiliated with Old Mill Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guardian Signature

**Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and Dr. Durbin and/or his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date