

**GOODE INTEGRATIVE HEALTH CARE**  
**CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE**

This information is needed so we can better serve you. Please fill in ALL portions of the form.  
If you need assistance, please ask our receptionist, and we will be happy to help you.

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status:  M  S  D  W Drivers License#/St \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Is your visit due to an accident?  Yes  No

Are you a Medicare patient?  Yes  No Are you a Medicaid patient?  Yes  No

Name of person to contact in case of emergency: \_\_\_\_\_

Their home and work phone number: \_\_\_\_\_

Who referred you to our office so we may thank them? \_\_\_\_\_

Primary Care and/or Referring Physician: \_\_\_\_\_

Medical Insurance Carrier Name: \_\_\_\_\_

Are you the policy holder?  Yes  No If not please fill out the following information.

Policy holder name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

## Present Complaints (please circle the appropriate ones)

Headache	Feet/hands cold	Head seems heavy	Pins and needles in arms R/L
Mental dullness	Depression	Confusion	Pins and needles in hand R/L
Loss of memory	Rib pain	Unbalanced	Pins and needles in legs R/L
Fainting	Neck stiffness	Constipation	Midback stiffness
Upper back pain	Lower back pain	Neck restriction	Nervousness
Shortness of breath	Fear	Upper back stiffness	Lower back stiffness
Eye strain/pain	Midback pain	Blurred vision	Double vision
Loss of smell	Irritability	Tension	Shoulder Pain

Difficulty in: Standing Sitting Bending Walking

Pain radiation to the: Right Arm Left Arm Right Leg Left Leg

Cannot Lift: Light Moderate Heavy Repetitive

Pain radiating to: Neck Base of skull Ribs Shoulders Arms

Pain in the: Foot Ankle Knee Hip Heel spurs

Other: \_\_\_\_\_

Since the time this(these) complaint(s) began, what, if anything have you tried that **did not** work? \_\_\_\_\_

Has the problem interrupted your sleep? Yes No How: \_\_\_\_\_

Does anyone in your family have the same or similar condition: Yes No  
Who: \_\_\_\_\_

List any doctors or therapists that you have seen for this complaint:

1. \_\_\_\_\_ Specialty \_\_\_\_\_  
2. \_\_\_\_\_ Specialty \_\_\_\_\_  
3. \_\_\_\_\_ Specialty \_\_\_\_\_

List any operations that you've had and approximate dates:

1. \_\_\_\_\_ Date \_\_\_\_\_  
2. \_\_\_\_\_ Date \_\_\_\_\_  
3. \_\_\_\_\_ Date \_\_\_\_\_  
4. \_\_\_\_\_ Date \_\_\_\_\_

Have you ever been involved in a motor vehicle accident? Yes No

If yes please list year(s): \_\_\_\_\_

Are you taking any medications? Yes No

Are you pregnant? Yes No Due Date: \_\_\_\_\_

Do you:      Smoke Yes No      Amount per day: \_\_\_\_\_  
                Drink Yes No      Light Medium Heavy  
                Exercise Yes No      Sometimes Frequently Regularly

**Relevant Medical History** (please circle the conditions you have or had previously)

Arthritis	Epilepsy	Muscular Dystrophy
Asthma	Fibromyalgia	Neck pain or spasms
Anemia	Hand or wrist pain	Neuritis
Back pain or spasm	Headaches	Numbness
Cancer	Heart problems	Polio
Concussion	Hepatitis	Rheumatic Fever
Convulsion	High blood pressure	Sinus trouble
Diabetes	HIV	Sciatica
Digestion problems	Measles	TB
Dizziness	Multiple Sclerosis	Venereal Disease

I attest that the above information is true and correct to the best of my knowledge. I further understand that any and all charges incurred by me in this office are **my sole responsibility**, despite any insurance plan, legal involvement, or settlement.

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

Parent or Guardian: \_\_\_\_\_

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

# GOODE INTEGRATIVE HEALTH CARE

Chiropractic ~ Physical Therapy ~ Massage Therapy ~ Wellness

## Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on \_\_\_\_\_, by the licensed doctors of chiropractic, medical doctors, and/or licensed therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is this pregnancy suspected or confirmed at this particular time.

\_\_\_\_\_(Patient's Name; Print) \_\_\_\_\_(Patient's Signature)

\_\_\_\_\_(Date) \_\_\_\_\_(Relationship or authority if not signed by patient)

\_\_\_\_\_(Witness)

3901 E. 3<sup>rd</sup> Street  
Bloomington, IN 47408  
Phone: 812-323-0700 Fax: 812-323-0702

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

Goode Integrative Health Care (the “Practice”) is committed to maintaining the privacy of your protected health information (“PHI”), which includes information about your health condition and history, as well as, the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operation of the Practice, and for other purposes permitted or required by law. This notice also details your rights regarding your PHI.

This Practice may employ multiple doctors of Chiropractic at any given time. However, for purposes of compliance with the Health Information Portability and Accountability Act (HIPAA) Privacy rules, all doctors are deemed to be a part of a single Organized Health Care Arrangement, which means: that they operate as an integrated unit; that they will share protected health information in order to carry out chiropractic care (including coverage for each other), payment for services rendered and health care operation; that this Notice is provided as a joint notice made by each doctor; and, that each of them will abide by the terms of this Notice.

This office maintains a sign-in-log at the reception area that you are asked to sign before seeing the doctor. Your name may be seen by others who are in the reception area.

Also, we provide most ongoing care in an “open adjusting” area. It is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. This means that statements made by you or office employees during treatment may be overheard by others. There are various interpretations under federal law with respect to what is known as “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open adjusting” environment are incidental matters. If you have comments or information you wish to share privately when you are brought to the “open adjusting” area or during treatment, please inform the doctor or staff and we will accommodate your request. You will have the opportunity to talk to your doctor and staff members in private.

In the course of your care as a patient at Goode Integrative Health Care, we may use or disclose personal and health related information about you in the following ways:

\*Your personal health information, including that of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

\*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

\*Your name, address, phone number, and your health care records may be used to correspond with you during or after your care. This may include contacting you regarding: appointment reminders, recommendation notices, birthdays, holidays, referral thank-you’s, practice events, information about alternatives to your present care, or other health related information (i.e. newsletters, e-mails, etc.) that may be of interest to you, as well as, other, similar correspondence.

Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. If you are not at home to receive an appointment reminder call, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. This request must be made in writing. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with you care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

\*If we are providing health care services to you based on the orders of another health care provider.

\*If we provide health care services to you in an emergency or if we are required by law to provide care and are unable to obtain your consent after attempting to do so.

\*if we are ordered by the courts or another appropriate agency. Also, when required by law (i.e. case of abuse and neglect) or for special government functions (i.e. military, veteran officers, foreign military) and to correctional institutions in the case of inmates.

\*If you are involved in a Workers' Compensation claim, we may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

\*If we contract with a business associate to provide a service necessary for your treatment, payment for your treatment and health care operations (e.g. billing service or transcription service). We will obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or request a copy of your health information for seven years from the date that the record was created or as long as the information remain in our files. In addition you have the right to request an amendment to your health information. The Practice has 30 days to comply with this written request. Requests to inspect, copy or amend your health related information must be made, in writing to the Practice's Privacy Officer, Samantha Miller, at 3901 E 3rd St., Bloomington, IN 47401-5538.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information, and to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Robert Goode.

This notice is effective as of November 1, 2008. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created, or as long as I remain under care, whichever is longer. If I discontinue chiropractic care in this office, this notice will remain in effect until the time the practice is required by Indiana law to retain my records. My signature acknowledges that a copy of this notice has been presented and made available to me on the date indicated.

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are a minor, or if you are being represented by another party

\_\_\_\_\_  
Personal Rep. (printed)

\_\_\_\_\_  
Personal Rep Signature

\_\_\_\_\_  
Date

Description of the authority to act on behalf of the patient.