SHANAHAN FAMILY
CHIROPRACTIC & ACUPUNCTURE

Dr. Kevin M. Shanahan, DC
1004 S Broadway St,
Toledo, IA 52342
641-484-3740

Today's Date_____

Name_____

Social Security #_____

Address_____

City_____ State_____

Zip_____ Phone_____

Birth date_____ Age_____

Circle one:
Gender: Female Male

Marital Status: M S D W

Student: Yes No
Name of school:_____

Employer_____

Job Title_____

Insurance Carrier_____

Have you been to a Chiropractor before?
Yes____ No____

What is the reason for your visit?

_____
_____
_____

Have you consulted another physician?____

If so, who?_____

List medications you are taking:

_____
_____

Whom may we thank for referring you?

_____

Please list any other health problems or conditions you may have in detail:

_____
_____
_____

Please list any previous surgeries you've had:_____

_____
_____
_____

Please list any previous traumas or fractures you've had:

_____
_____
_____

(OVER)

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Health Questionnaire

Please put a check mark next to a symptom or condition that you have experienced:

___ Low Back Pain
___ Pain Between Shoulders
___ Arm Problems
___ Painful/Stiff Joints
___ Weak or Sore Muscles
___ Numbness
___ Neck Problems
___ Paralysis (muscle function loss)
___ Leg or Walking Problems
___ Swollen Joints
___ Rapid Heartbeat
___Neuritis (nerve inflammation)

___ Ruptures
___ Bowel Trouble
___ Constipation
___ Black/Bloody Stool
___ Diarrhea
___ Bladder Trouble
___ Excessive Urination
___ Difficulty Urinating
___ Discolored Urine
___Chest Pain
___ Headaches
___ Convulsions

___ Persistent Cough
___ Coughing Blood
___ Vomiting Food or Blood
___ Gall Bladder Trouble
___ Liver Trouble
___ Breathing Problems
___ Blood Pressure Problems
___ Poor Appetite
___ Excessive Appetite
___ Abdominal Pain
___ Diabetes
___ Anemia

___ Dizziness
___ Fainting
___ Hearing Loss
___ Ear Problems
___ Depression
___ Asthma
___ Arthritis
___ Vision Problems
___ Eye Strain

Answer questions in this box ONLY if your condition is due to an accident.

Date of occurrence:_____

Type of accident (Circle one): Auto Work Home Other

To whom have you made a report of your accident? (Circle one)

Auto Insurance Employer Worker's Comp Other

Attorney Name (if applicable):_____

For females only:

Please indicate the first day of your last menstrual cycle (a calendar is at the reception desk if you need it.) Date:_____

I hereby deny that I am pregnant and will notify the doctor and staff if I become pregnant.

X_____
Signature

Today's Date: _____

Whom may we contact in the case of an emergency? _____ Phone:_____
(Nearest relative not living with you)

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on both pages and certify that this information is correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient's Signature X_____ **Date:** _____

Parent's Signature (if Minor) X_____ **Date:** _____

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Privacy Notice

This notice, which is required by state and federal law, describes how information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Protected Information: While receiving care from our facility, information, including your medical history, treatment, and payment for your health care may be originated and/or received by Shanahan Family Chiropractic, P.C. Information which can be used to identify you and relates to your medical care, or your payment for medical care, is protected by state and federal law (Protected Information.)

- Shanahan Family Chiropractic, P.C. hereafter referred to as SFC, will safeguard the security and confidentiality, as set forth in the Health Insurance Portability and Accountability Act (HIPAA), both physically and electronically, of Protected Information our patients provide to us.

- SFC will conduct its business in such a manner that Protected Information will be submitted as necessary, including but not limited to, hospitals, health care providers outside our facility who may also be involved in your care, nursing home or rehabilitation facilities, pharmacies, peer review, quality assurance, payment purposes, your insurance company or other third-party payors. SFC will request any necessary business associate or organization who receives Protected Information maintain the confidentiality standards as set forth in HIPAA.

- Worker's Compensation Protected Information will be disclosed as authorized and to the extent necessary to comply with laws relating to worker's compensation or other programs providing benefits for work-related injuries or illness without regard to fault. This includes work-related injuries that are alleged, under investigation, or compensable.

- Protected Information may be released if you are involved in legal or litigated proceedings, including but not limited to, lawsuits, assisting and complying with law enforcement, administrative or court proceedings.

- SFC will maintain an internal policy that limits access and viewing of Protected Information to only those employees who need to have access to your Protected Information. SFC employees who violate this policy are subject to disciplinary action.

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Acknowledgment of Privacy Notice

I, _____ acknowledge that I have received a copy of Shanahan Family Chiropractic, P.C.'s Privacy Notice which summarizes some of the ways my Protected Information may be used and disclosed.

X_____ _____
(Signature of Patient) (Date Signed)

X_____ _____
(Personal Representative of individual, if individual unable to sign) (Date Signed)

X_____ _____
(Signature of Witness) (Date Signed)

Individual (or personal representative of individual) did not sign the acknowledgement for the following reason:

(check one of the reasons below)

- ☐ Individual refused
- ☐ Individual refused, stating he/she has already signed an acknowledgement
- ☐ Individual unable to sign because of medical condition
- ☐ There was not a personal representative of the individual available to sign
- ☐ Other (Explain)

_____
_____
_____
_____

X_____ _____
(Witness Signature) (Date)