hood county
NATURAL HEALTH
CLINIC

Dr. Ken Parker • 4425 E. Hwy 377, Ste 102, Granbury, TX 76049
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Health Insurance Portability & Accountability Act (HIPAA) Consent Form
THIS NOTICE DESCRIBES HOW RELATED INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION

In the course of your care as a patient at our office, we may use or disclosure personal and health related information about you in the following ways: 1)Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment of treatment. 2) Your health records as well as your billing records may be disclosed to another party, such as insurance carriers (HMO,PPO,etc.),or your employer(if they are responsible for payment). 3)Your name, address, phone number, email and your health records may be used to contact you regarding appointment reminders, missed appointments notifications, birthday cards, holiday related cards, information about treatment alternatives or other health related information. A message may be left on your answering machine. 4) Your name may be listed on our referral board, in testimonial letters you provide, or on our kid's board if applicable. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you. Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the 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
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care

We normally provide information about your health care 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. By signing below, I acknowledge that I have read the above information and give full disclosure of my information.

Patient's/Guardian Signature **Date**

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care or any clinic services that he/she deems necessary in my case: and further authorize him/her to disclose all or any part of my (patients) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patients employer.

Patient's Signature **Date**

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Fax: (866) 405-9081
4425 E. Hwy 377 #102
Granbury, TX 76049
drparker@drkenparker.com
www.hcnaturalhealth.com

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State_____ ZIP_____

Cell Phone (____) ____-_____ Cell Phone Carrier _____

Home Phone (____) ____-_____ Work Phone (____) ____-_____

e-mail address: _____

Who may we thank for referring you? _____

Occupation _____ Employer_____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply):

Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

_____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Emergency Contact:

Full Name: _____

Home: _____ Mobile: _____

Relationship: Child / Parent / Spouse / Other:_____

Review of Health History

Please mark the following conditions you may have had or have now? *(- have had or + have now)*

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- ❍ Recent Weight Change
- ❍ Fever
- ❍ Fatigue
- ❍ *None in this Category*

Musculoskeletal:
- ❍ Low Back Pain
- ❍ Mid Back Pain
- ❍ Neck Pain
- ❍ Arm Problems _____
- ❍ Leg Problems_____
- ❍ Painful Joints
- ❍ Stiff/Swollen Joints
- ❍ Sore/Weak Muscles or Joints
- ❍ Muscle Spasms/Cramps
- ❍ Broken Bones _____
- ❍ Other:_____
- ❍ *None in this Category*

Neurological:
- ❍ Numbness or tingling sensations
- ❍ Loss of Feeling
- ❍ Dizziness or light headed
- ❍ Frequent or Recurrent Headaches
- ❍ Convulsions or seizures
- ❍ Tremors
- ❍ Stroke
- ❍ Have you ever had a head injury?
- ❍ Ever been in an auto accident?
- ❍ Other:_____
- ❍ *None in this Category*

Mind/Stress:
- ❍ Nervousness
- ❍ Depression
- ❍ Sleep Problems
- ❍ Memory Loss or Confusion
- ❍ Other:_____
- ❍ *None in this Category*

Genitourinary:
- ❍ Sexual Difficulty
- ❍ Kidney Stones
- ❍ Burning/Painful Urination
- ❍ Change in force/strain with Urination
- ❍ Frequent Urination
- ❍ Blood in Urine
- ❍ Incontinence or Bed Wetting
- ❍ Other:_____
- ❍ *None in this Category*

Gastrointestinal:
- ❍ Loss of Appetite
- ❍ Blood in Stool
- ❍ Change in Bowel Movements
- ❍ Painful Bowel Movements
- ❍ Nausea or Vomiting
- ❍ Abdominal Pain
- ❍ Frequent Diarrhea
- ❍ Constipation
- ❍ Other: _____
- ❍ *None in this Category*

Cardiovascular & Heart:
- ❍ Chest Pains
- ❍ Rapid or Heartbeat changes
- ❍ Blood Pressure Problems
- ❍ Swelling of Hands, Ankles, or Feet
- ❍ Heart Problems
- ❍ Other: _____
- ❍ *None in this Category*

Respiratory:
- ❍ Difficulty Breathing
- ❍ Persistent Cough
- ❍ Coughing Blood
- ❍ Asthma or Wheezing
- ❍ Lung Problems
- ❍ Other:_____
- ❍ *None in this Category*

Eyes and Vision:
- ❍ Wear contacts/glasses
- ❍ Blurred or double vision
- ❍ Glaucoma
- ❍ Eye disease or injury
- ❍ Other: _____
- ❍ *None in this Category*

Ears, Nose and Throat:
- ❍ Bleeding gums / mouth sores
- ❍ Bad Breath or bad taste
- ❍ Dental Problems
- ❍ Swollen throat or voice change
- ❍ Swollen glands in neck
- ❍ Ringing in the ears
- ❍ Ear - Ache/Ringing/Drainage
- ❍ Sinus / Allergy problems
- ❍ Nose Bleeds
- ❍ Hearing Loss
- ❍ Other: _____
- ❍ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❍ Thyroid problems
- ❍ Diabetes
- ❍ Excessive Thirst or urination
- ❍ Cold Extremities
- ❍ Heat or Cold intolerance
- ❍ Change in hat or glove size
- ❍ Dry skin
- ❍ Glandular or hormone problem
- ❍ Swollen Glands
- ❍ Anemia
- ❍ Easily Bruise or Bleed
- ❍ Phlebitis
- ❍ Transfusion
- ❍ Immune system disorder
- ❍ Other: _____
- ❍ *None in this Category*

Skin and Breasts:
- ❍ Rash or Itching
- ❍ Change in Skin Color
- ❍ Change in hair or nails
- ❍ Non-healing sores
- ❍ Change of appearance of a mole
- ❍ Breast Pain
- ❍ Breast Lump
- ❍ Breast Discharge
- ❍ Other: _____
- ❍ *None in this Category*

Women Only:

Are you pregnant?
- ❍ **Yes - *Due Date*___/____/____**
- ❍ **No - *Last Menstrual Period***
  ___/____/____
- ❍ Infertility
- ❍ Painful or Irregular periods
- ❍ Vaginal Discharge
- ❍ Other: _____
- ❍ *None in this Category*

Pregnancies with Outcome & Date:

_____
_____
_____

Comments:

_____
_____

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If dietary changes are indicated would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
Would you take whole food supplements if indicated?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day **| W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) **| M -** Consume this monthly **| O -** Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else which may help to better understand you which has not been discussed?

_____
_____
_____
_____

Why are you here at this point in time?

_____
_____
_____
_____

What can we do to make you happier?

_____
_____

I consent to a professional and complete chiropractic examination, nutrition examination (including muscle response testing) and to any radiographic examination that the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____