Baxter Health Center

"Where we shape health, not just backs"

Name: _____
Last First Middle Nickname

Address: _____
Street Apt# City State Zip

Home Phone: _____ Cell Phone: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Marital Status: S M D W

Social Security#:_____

Would you like to receive free monthly nutritional newsletters by email? Yes_____ No_____

E-Mail:_____

Occupation: _____ Employer: _____

Address: _____ Work Phone: _____

Name of Spouse: _____ Date of Birth: _____/_____/_____

Employer: _____ Occupation: _____

Who may we thank for referring you?:_____

Insurance Type: Private Health Medicare Auto Work Comp None

Relationship to insured: self spouse child

Name of primary insurance: _____ ID#: _____
Name of secondary insurance: _____ ID#: _____

***IS THIS AN AUTO ACCIDENT? _____ IS THIS A JOB RELATED INJURY?_____

***Have you seen a chiropractor in the last twelve (12) months? Yes_____ No_____
Who did you see? _____ For how long? _____
For what condition or area of body? _____

***Please indicate by checking yes or no if you have Culinary insurance benefits Yes_____ No_____

***Our office is required to maintain original x-rays and records as property of this office.

_____ _____
Patient Signature Date

Mark D. Baxter, D.C., C.M.U.A.
6332 South Rainbow Blvd., Suite #120, Las Vegas, Nevada 89118 P: 702-891-8833, F: 702-891-8866

Baxter Health Center Consultation & Examination

Last Name _____ First _____ M.I. _____ Today's Date_____/_____/_____

DOB: _____/_____/_____ AGE: ____ Sex: M F Marital Status: ☐Single ☐Partner ☐Married ☐Separated ☐Divorced ☐Widowed

Names & Ages of Children _____ Exam Time: Start _____ Finish_____

LEVEL	HPI = Component 1	ROS = Component 2	PFSH = Component 3
☐ Problem Focused	Brief 1-3	None	None
☐ Expanded Problem Focused	Brief 1-3	Problem pertinent	None
☐ Detailed	Extended 4 or more	Extended 2-10	Pertinent 1
☐ Comprehensive	Extended 4 or more	Complete 11 or more	Complete 2 or more

HPI History of Present Illness:

Reason for this visit:_____

☐ No Trauma or Mechanism of Trauma: _____

Prior Interventions/Treatment/Self Treatment: _____

Secondary Complaints:_____

Current Medications: _____

Allergies: _____

Location/Radiation: _____

Onset/Duration: Sudden/Gradual/Insidious _____Hours/Days/Weeks/Months/Years Date: _____/_____/_____ Time:_____

Timing: Intermittent (0-25%) Occasional (26-50%) Frequent (71-55%) Constant (76-100%)

Comes every _____Hours/Days/Weeks/Months Lasts _____ Hours/Days/Weeks/Months

Quality: Aching, Burning, Cramping, Tingling, Numb, Pressure, Throbbing, Sharp, Stabbing, Shooting, Dull, Other____ _____

Severity (0 none - 10-severe): When Worse: _____ When Better: _____ Right Now: _____

Does it impair any of your activities? _____

Context: Have you ever had this before? _____ If so, when? _____ Is this episode better or worse? _____

Associated signs/symptoms: nausea/vomiting/constipation/diahrrea/fever/chills/bleeding/pain/other _____

Modifying Factors: Better/Worse with activity/sleep/rest/sitting/laying down/ice/heat/medications/nutrients/other _____

Review of Systems	(-)	Check all CURRENT positive findings ☐ ALL NEGATIVE Height ____ Current Weight ____ Ideal Weight____
Consittutional		Weight Loss ☐ Weight Gain ☐ Fever ☐ Chills ☐ Poor Apetite ☐ Fatigue ☐ Insomnia ☐ Night Sweats ☐
Eyes		Blurry Vision ☐ Eye Pain ☐ Eye Discharge ☐ Eye Redness ☐ Impaired Vision ☐ Dry Eyes ☐ Double Vision ☐
ENT		Sore Throat ☐ Hoarseness ☐ Ear Pain ☐ Hearing Loss ☐ Ear Discharge ☐ Nose Bleeds ☐ Tinnitus ☐ Sinus ☐
Cardiovascular		Chest Pain ☐ Palpatations ☐ Rapid Heart Rate ☐ Murmur ☐ Poor Circulation ☐ Swelling in Legs or Feet ☐ HIgh Blood Pressure☐ Heart Disease☐ High Cholesterol orTriglycerides ☐ Pacemaker☐ Periph. Vascular Dis☐
Respiratory		Shortness of Breath ☐ Chronic Cough ☐ Coughing up Blood ☐ History of Tuberculosis ☐ Excess Sputum ☐
Gastrointestinal		Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Blood in Stool ☐ Frequent Heartburn ☐ Difficulty Swallowing ☐
Genitourinary		Frequent Urination ☐ Bloody Urine ☐ Painful Urination ☐ Incontinence ☐ Urinary Retention ☐ Frequent UTI's ☐
Skin		Rash ☐ Hives ☐ Hair Loss ☐ Skin Sores ☐ Itching ☐ Skin Thickening ☐ Nail Changes ☐ Mole Changes ☐
Musculoskeletal		Joint Pain ☐ Muscle Aches ☐ Leg Cramps ☐ Muscle Weakness ☐ Bone Pain ☐ Joint Swelling ☐ Back Pain ☐ Osteoarthritis ☐ Gouty Arthritis ☐ Headaches ☐
Neurological		Numbness ☐ Tingling ☐ Dizziness ☐ Loss of Balance ☐ Seizures ☐ Tremors ☐ Slurred Speach ☐ Stroke ☐ Recent changes in your ability to see ☐ hear ☐ taste ☐ smell ☐ feel hot or cold sensations ☐
Heme/Lymphatic		Bruise Easily☐ Blood Clots☐ Prolonged Bleeding☐ Swollen Nodes☐ Low Blood Count☐ Fluid in Arm or Leg☐
Allergy/Immune		Hay Fever ☐ Frequent Infections ☐ Allergies ☐ Auto-Immune Disease ☐ Positive TB Skin Test ☐ Hepatitis ☐ Pos. HIV/AIDS ☐ Rheumatoid Arthritis ☐
Endocrine		Goiter☐ Heat Intolerance ☐ Cold Intolerance ☐ Increased Thirst ☐ Excess Sweating ☐ Changed Skin Color ☐
Psychiatric		Depression☐ Anxiety☐ Loss of Motivation☐ Suicidal Thoughts☐ Drug or Alcohol Dependance☐ Panic Attacks ☐

Past, Family & Social History: Pertinent 1 ☐ Complete 2 or more ☐ **2.**

Your Own Personal Past Medical History: Dates & Types of Surgeries & Hospitalizations:

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Heart Attack	☐	☐	Kidney Stones	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	COPD	☐	☐	Stomach Ulcer	☐	☐
Hepatitis	☐	☐	Seizures	☐	☐	Liver Disease	☐	☐
Tuberculosis	☐	☐	Depression	☐	☐	Heart Surgery	☐	☐
Blood Clots	☐	☐	Thyroid Dis.	☐	☐	Congestive Heart Failure	☐	☐

Other past conditions not listed above: _____

Social History: Marital Status _____ Occupation _____

Tobacco: Never Smoked ☐ Ex Smoker ☐ Current Smoker ☐ Packs Per Day _____ Years Smoked _____

Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ Snuff ☐

Alcohol: Never Use ☐ Wine ☐ Beer ☐ Hard Liquor ☐ _____ Glasses per Day ☐ Week ☐ Month ☐

Caffeine: Never Use ☐ Coffee ☐ Soda Pop ☐ Tea ☐ _____ Cups per Day ☐ Week ☐ Month ☐

Current Medications You Take: _____

Your Family's Medical History: Please list any known medical conditions in your family:

Father: _____ Mother: _____

Father's Father: _____ Mother's Mother: _____

Father's Mother: _____ Mother's Father: _____

Father's Siblings: _____ Mother's Siblings: _____

Your Siblings: _____ Your Children: _____

System-Specific Examination Procedures:

Constitutional	Seated B.P. ___/___ Pulse ___ ☐Fever ☐Normocaloric Ht ___ Wt ___
Eyes	Conjunctiva & Lids
ENT	Auditory Canal, Drum, Thyroid & Jugular Palpation, Teeth, Tongue
Cardiovascular	Lower extremity perfusion, Radial & Pedal Pulses, Carotid & Aorta Pulses
Respiratory	Assessment of respiratory effort, Lung auscultation
Gastrointestinal	Abdominal exam, liver & spleen, abdominal purcussion
Skin	Dermatitis, rashes, scars, lipomas, moles, ulcers, etc.
Musculoskeletal	Posture, kinesiological
Neurological	Upper & lower extrem. ref., touch, pin, vibration, proprioception, cranials
Hematologic/Lymphatic	Extremity edema, palpation of lymph nodes in neck and axillae
Endocrine	Hormone Q., Adrenal Q., Rogoff's Test, Ragland's Test
Psychiatric	Neurotransmitter Q., Orientation to time, place, person, mood & affect
Abnormal Findings:	

Current Health Factors: 3.

Date of last physical exam:_____/_____/_____ Physician name: _____

Laboratory procedures performed: _____

Laboratory findings: _____

Imaging studies performed (x-rays, MRI, CT, etc.): _____

Imaging studies performed of what region?: _____

Imaging results: _____

Last x-rays of what spinal region taken when?: _____

Circle how much stress you are experiencing on a scale of 1 to 10 (1 being the lowest: 1 2 3 4 5 6 7 8 9 10

What is the major cause of your stress? _____

Have you had an unintentional weight loss of ten pounds or more in the last three months? _____

Which potentially harmful substances, if any, (e.g. chemicals, solvents, radioactivity, pesticides, etc.) are you exposed to at work, home or other locations? _____

What risky or threatening activities do you engage in at home, work or recreationally?_____

Do you use: ☐corrective lenses ☐Dentures ☐Hearing aid ☐heart pacemaker ☐other implanted electronic device

Please identify any prosthetics, implants, orthotics, TMJ splints or other medical devices you use: _____

Please list any fractures you have had and when: _____

Were any metal screws, plates or rods used to stabilize the fracture? _____

Medical (Women): # of children _____ # of pregnancies _____ C-section?_____ multiple births? _____

Age at first period _____ Form of birth control _____ Date of last gynecological exam ____/____/____

Date of last day of last period _____/_____/_____ Length of period _____ days. Length of monthly cycle _____ days

Mammogram ☐+ ☐- PAP ☐+ ☐- Hysterectomy? _____ Complete or Partial? _____ Menopause? ☐yes ☐no

Any recent changes in normal menstrual flow (e.g. heavier, lighter, large clots, spotting between periods) _____

Endometriosis ☐ Infertility ☐ Fibrocystic Breasts ☐ Uterine Fibroids ☐ Ovarian Cycts ☐ PMS ☐

Uterine Cancer ☐ Ovarian Cancer ☐ Cervical Cancer ☐ HPV infection Sexually Transmitted Disease ☐

Pelvic Inflammatory Disease ☐ Decreased sex drive (libido) ☐ Vaginal infections ☐ Bladder Infections ☐

Do you feel less connected with your higher thoughts and emotions? ____ Do you feel like you've lost yourself?____

Medical (Men): Difficulty Starting or Stopping Stream☐ Benigh Prostatic Hyperplasia (BPH)☐ Elevated PSH ☐

Prostate Cancer ☐ Decreased Sex Drive (Libido)☐ Infertility☐ Sexually Transmitted Disease☐ Decreased Energy or Motivation☐ Other:

Health Habits: How many ounces of water do you drink each day? _____ Days per week of exercise? _____

How many minutes do you exercise each time you exercise? _____ What type of exercise do you do? _____

Nutrition & Diet:: Mixed food diet (animal & vegetable) ☐ Vegetarian ☐ Vegan ☐ Zone Diet ☐ Atkins Diet ☐

Food Restrictions: All Gluten ☐ Dairy☐ Eggs☐ Soy☐ Corn☐ Salt ☐ Fat☐ Total Calorie Restriction ☐

Eating Habits: Meals per day: 3☐ 2☐ 1☐ Skip breakfast☐ Graze☐ Eat Fast Food ___ times per wk☐ mo☐

# of servings per day of fruits ___ dark green vegetables ___ yellow, orange red vegegables ___ whole grains ___ meat ___

beans, peas, lentils ___ poultry ___ regular fish ___ grass-fed beef or buffalo ___ wild fish ___ dairy ___ eggs ___

What nutritional supplements do you take? _____

Would you like to: have more energy☐ be stronger☐ have more endurance☐ increase your sex drive☐ be thinner☐

be more muscular☐ improve complexion☐ have stronger nails☐ have healthier hair☐ be less moody☐ be less depressed☐

be less indecisive☐ feel more motivated☐ be more organized☐ think more clearly☐ improve memory☐ sleep better☐

perform better mentally☐ decrease allergies☐ rreduce your risk of inherited disease tendencies (e.g. cancer, heart disease, diabetes)☐ have agreeable breath☐ have agreeable body odor☐ optimize your physical, mental & emotional health☐

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Financial Responsibility Acknowledgement

Thank you for choosing us as your health care provider. The following is our Financial Policy. **Please read this carefully.** If you have any questions or concerns about our payment policies, please do not hesitate to ask our Billing Department.

Payment / Co-pays for services are due at the time services are rendered. We accept cash, checks, and for your convenience, most major credit cards. We will submit an insurance claim on your behalf.
If your insurance coverage/company changes please notify the Billing Department immediately. We cannot submit claims properly if you do not supply us with the correct information.

You must understand and sign that you acknowledge the following:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

2. You authorize the release of any medical information necessary to process your insurance claim(s) and also certify that all insurance given to this office is correct and complete.

3. You authorize your insurance company to pay by check and for that check to be mailed to this office directly, the benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. You agree to pay, in a current manner, any remaining balance of applicable charges. You agree that this office be given power of attorney to endorse/sign your name on any and all drafts for payment of charges from this office.

4. You are responsible for knowing your insurance benefits. Does your insurance require a Primary Care Physician (PCP) Referral? Is Dr. Baxter a Participating Provider? Do you have a deductible? What is the co-pay per visit? Does your policy have limits (ie visit or dollar maximums per year?) on chiropractic services?

5. Fees for services rendered may include: co-insurance, co-payments, and unpaid deductibles. Also, most insurance carriers do not pay for vitamins and/or nutritional supplements, in-office tests, hot/cold packs or support belts: These fees will be due at the time of treatment.

6. If your insurance carrier does not pay in full within 60 days, we ask that you contact them. If your insurance does not pay in full within 90 days, the charges will be transferred to your responsibility, and may possibly start accruing interest charges. We will require you to pay the balance due with cash, check, or credit card, even though your insurance carrier may eventually process your claim.

7. Returned checks are subject to a return check charge of $25.00. Patient balances over 30 days old after insurance pays on claim may be subject to additional interest charges.

8. We reserve the right to send you to collections for unpaid balances. You will be responsible for any collection fees, legal fees, or court costs.

9. Please be kind enough to give us a 24-hour notice if you must cancel your appointment. We do not like imposing our office policy of a $30.00 cancellation fee, and we are sure you will not like paying it. Thank you for your consideration in this matter.

We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our billing department so that we can assist you in the management of your account.

_____ _____

Signature of Patient Date

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures, muscular strain, ligamentous sprain, joint dislocations, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. Ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a many undesirable side effects and patient dependence in a significant number of cases. (100,000 deaths/year from properly prescribed medication — JAMA 04/15/98)

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. (2.2 million hospitalizations/year from properly prescribed medications — JAMA 04/15/98)

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce flexibility, and induce chronic pain. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read, or have had read to me, the above explanation of chiropractic treatment and risks. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from any and all licensed health care professionals in this office.

_____	_____	_____
Printed Name	**Signature**	**Date**

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HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses & Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003. We are require by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ **Signature**_____ **Date**_____

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