Dr. Blair Miller, D.C.
Dr. Marie Pappas, D.C.
Holistic Chiropractic and Wellness PLLC

2251 Double Creek Dr, Suite #401 Round Rock, TX 78664
512-246-0220

Welcome to our office! *PLEASE PRINT AND COMPLETE ALL SECTIONS*

Appointment Date: _____ Referred By: _____
Name (first, middle, last) _____Preferred Name: _____
Address_____ City_____ State_____ Zip_____
Home Phone (____)_____Work (____)_____Cell (_____)_____
Social Security # _____ Date of Birth___/___/___ Age_____ □Male □Female
Occupation_____Employer_____
Marital Status: □M □S □W □D Name of Spouse:_____
Names and Ages of children_____
Email: _____
How did you hear about us? _____

TELL US ABOUT ALL PRESENT AND PAST CONDITIONS:

Please mark, in front of each statement **ANY** that apply to you. Place and **"X"** for any **present conditions** and, **"O"** for any **past conditions** that are no longer an issue. **If it does not apply to you, please leave it blank**.

Extremities	**Respiratory**	**Other Conditions**	**Male**
____ Hip Pain or Stiffness R/L	____Asthma	____ Headaches/Migraines	____ Impotence
____Foot Pain Stiffness R/L	____Chest Pain	____ Trouble Sleeping	____ Prostate Problems
____Wrist Pain or Stiffness R/L	____ Difficulty Breathing	____ Excessive Sweating	**Female**
____Elbow Pain or Stiffness R/L	____ Lung Problems	____ Cancer Type:_____	____ Menopausal Problems
____Shoulder Pain or Stiffness R/L	**Digestion**	____ Emotional/Mental Disorders	____ Menstrual Cycle Problems
____ Pubic Bone Pain	____ Heartburn	____ Learning Disability	**Urinary Tract**
____ Jaw Pain or Clicking or Popping R/L	____ Digestion Problems	____ Nervous/Irritable	____ Kidney Trouble
____Knee Pain or Stiffness R/L	____ Gallbladder Problems	____ Loss of Memory	____ Frequent Urination
Spine	____ Colon Trouble	____ Dizziness/Loss of Balance	____ Bedwetting
____Head/Shoulders Feel Heavy/Tired	____ Diarrhea/ Constipation	____ Arthritis	____ Other:
____Neck Pain or Stiffness R/L	____ Hemorrhoids	____ Epilepsy/Convulsions	**Organ Problems/Dysfunction**
____Upper Back Pain or Stiffness R/L	**Immune**	____ Knocked Unconscious	____ Diabetes
____Mid Back Pain or Stiffness R/L	____ Skin Problems	____ Frequent Ear Infections	____ Liver Trouble
____Low Back Pain or Stiffness R/L	____ Sinus / Allergies	____ Ringing in Ear R/L	____ Hepatitis
____Pain with cough/sneeze or strain	____ Frequent Colds/Flu	____ Hearing Loss R/L	____ High/Low Blood Pressure
____Difficulty with (circle all that apply) Standing/Walking/Sitting/ Bending/Lifting/Twisting	____ Anemia	____ Trouble Concentrating	____ Heart
Numbness/Tingling or Pain in:	____ Other:	____ AIDS/HIV	
____ Arms/ Hand/Fingers R/L		____ Fracture/Dislocation of Bones:_____	
____ Legs / Feet / Toes R/L		____ Other:	

Patient Name: _____ Date: _____

TELL US ABOUT YOUR PRESENT AND PAST HEALTH CONDITION(S)

1. Primary Complaint(s): _____
2. Secondary Complaint(s):_____
3. Tertiary Complaint(s):_____
4. Have you become discouraged about handling this problem? □ Yes □ No
5. Does this problem interfere with the following areas of your life?

   Family: □ Yes □ No If yes, please explain: _____
   Work: □ Yes □ No If yes, please explain: _____
   Hobbies: □ Yes □ No If yes, please explain: _____
   Life: □ Yes □ No If yes, please explain: _____

6. How much older does this problem make you feel: _____
7. On a scale of 1 to 10, with 10 being the most, rate your commitment level in helping us solve this problem: _____
8. Tell us about your past medical history: What? When? Results?

   Surgeries: _____
   Hospitalizations: _____
   Major Illness: _____

9. Are you currently taking anti-coagulant medication/therapy? □ Yes □ No
10. When did you last see a chiropractor? _____ Dr. Name:_____

    For what reason? _____
    What spinal maintenance programs were you given to maximize the stability of your spine?
    _____
    Did you follow the Doctor's recommendations? □ Y □ N If no, Why not? _____
    Why are you changing chiropractors? _____

IF YOU'RE PREGNANT, PLEASE PROVIDE THE FOLLOWING INFORMATION

1. How many weeks prenatal are you? _____
2. OB/GYN or midwife name: _____ Practice name: _____
3. Delivering at: _____
4. Due date: _____
5. Baby name: _____ □ Female □ Male
6. Gestational diabetes? □ Yes □ No
7. Pre-eclampsia? □ Yes □ No
8. Placenta is: □ Anterior □ Posterior
9. I need more education in prenatal anatomy:
   □ Sacrum □ SI Joint □ Round Ligament □ Psoas □ Piriformis

I verify that all of my information is correct and that I have completed all questions with as much information as is possible.

Patient's Signature: _____ Date: _____

FAMILY HEALTH HISTORY

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation "C" under his/her column, and those that are past health problems by the designation of "P" under his/her column. Leave blank those spaces that do not apply.

	Father	Mother	Spouse	Siblings				Children			
Condition:	**Age: _____**	**Age: _____**	**Age: _____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**
ADHD											
Allergies											
Arthritis											
Asthma											
Autism											
Back Trouble											
Bed Wetting											
Bursitis											
Cancer											
Chest Pain											
Colic											
Constipation											
Crohn's Disease											
Depression											
Diabetes											
Diarrhea											
Disc Problems											
Down Syndrome											
Ear Infection											
Emotion Issues											
Emphysema											
Epilepsy											
Headaches											
Migraines											
Heartburn											
Heart Trouble											
High Blood Press											
IBS											
Indigestion											
Infertility											
Insomnia											
Kidney Trouble											
Neck Pain											
Neuritis											
Nervousness											
Pinched Nerve											
Scoliosis											
Sinus Trouble											
Other: _____											

Detailed Information - Primary Complaint

1. What is your **PRIMARY** complaint? _____
2. How long have you suffered with this? _____
3. How did your primary complaint start? _____
4. Please circle or describe what your primary complaint feels like:
   Aching Tight Burning Sharp Numbing Tingling Dull Weak Shooting
   Other: _____
5. How often does your complaint occur? Constant Intermittent Occasional
6. How would you rank your primary complaint on a pain scale from 1 to 10; 10 being the most painful: ___
7. Does your complaint ever radiate to any other areas? □ Yes □ No If yes, please describe: _____
   _____
8. Currently, what makes it better? _____
9. Currently, what makes it worse? _____
10. Please circle all that you have done so far to help with your primary complaint:

    Massage Medicine Physical Therapy Exercise Rest Ice Heat Herbal Remedy

    Chiropractic Adjustments Yoga Surgery Psychiatrist/Psychologist/Counseling Nothing

11. What medication(s), if any, are you taking for your primary complaint? _____
12. If you have had surgery regarding this complaint, please describe it: _____

_____

Detailed Information - Secondary Complaint

1. What is your **SECONDARY** complaint? _____
2. How long have you suffered with this? _____
3. How did your primary complaint start? _____
4. Please circle or describe what your primary complaint feels like:
   Aching Tight Burning Sharp Numbing Tingling Dull Weak Shooting
   Other: _____
5. How often does your complaint occur? Constant Intermittent Occasional
6. How would you rank this complaint on a pain scale from 1 to 10; 10 being the most painful? _____
7. Does your complaint ever radiate to any other areas? □ Yes □ No If yes, please describe: _____
   _____
8. Currently, what makes it better? _____
9. Currently, what makes it worse? _____
10. Please circle all that you have done so far to help with your secondary complaint:

    Massage Medicine Physical Therapy Exercise Rest Ice Heat Herbal Remedy

    Chiropractic Adjustments Yoga Surgery Psychiatrist/Psychologist/Counseling Nothing

11. What medication(s), if any, are you taking for your primary complaint? _____
12. If you have had surgery regarding this complaint, please describe it: _____

_____

Detailed Information - Tertiary Complaint

1. What is your **TERTIARY** complaint? _____
2. How long have you suffered with this? _____
3. How did your secondary complaint start? _____
4. Please circle or describe what your secondary complaint feels like:

   Aching Tight Burning Sharp Numbing Tingling Dull Weak Shooting
   Other: _____
5. How often does your complaint occur? Constant Intermittent Occasional
6. How would you rank this complaint on a pain scale from 1 to 10; 10 being the most painful? _____
7. Does your complaint ever radiate to any other areas? □ Yes □ No If yes, please describe: _____
   _____
8. Currently, what makes it better? _____
9. Currently, what makes it worse? _____
10. Please circle all that you have done so far to help with your secondary complaint:

    Massage Medicine Physical Therapy Exercise Rest Ice Heat Herbal Remedy

    Chiropractic Adjustments Yoga Surgery Psychiatrist/Psychologist/Counseling Nothing
11. What medication(s), if any, are you taking for your primary complaint? _____
12. If you have had surgery regarding this complaint, please describe it: _____

_____

RELEASE AND CONSENTS

AUTHORIZATION FOR DIAGNOSIS AND TREATMENT

I authorize Dr. Blair Miller, D.C. and/or Dr. Marie Pappas, D.C. to administer diagnoses and treatment. I also authorize the provider(s) to release any information required to process insurance claims.

Signature: _____

Printed Name: _____ Date: _____

CONSENT TO X-RAY EXAMINATIONS

If and when deemed necessary, I do hereby consent to X-ray examination, to be performed at an outside facility.

Females: I will notify the doctors if I believe that I could be pregnant so that the proper precautions will be taken.

Last Menstrual Period Date _____

Signature: _____ Date: _____

HIPAA

Consents Name of Practice: Holistic Chiropractic and Wellness PLLC
Address: 2251 Double Creek Dr, Suite #401
Round Rock, TX 78664
Privacy Contact: Dr. Blair Miller, D.C.
Telephone: 512-246-0220

** I understand that I do not have to sign this authorization in order to receive treatment from this practice, but when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

NOTICE OF PRIVACY PRACTICE RECEIPT:
I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient: _____
Signature of Patient: _____
Date: _____
Patient's Date of Birth: _____

For Personal Representative of the Patient (only if applicable)

Print Name of Personal Representative: X_____
Relationship (parent, guardian, etc.): X_____
Signature of Personal Representative: X_____
Reason Patient unable to sign: _____

_____ _____
Practice Employee Date

ALL PATIENTS PLEASE PROVIDE THE FOLLOWING

May we release appointment, billing and medical information to anyone other than you? ___YES ___NO

Name(s) of the person(s) we may release your information to: _____

* I hereby authorize Holistic Chiropractic and Wellness PLLC to release periodic status reports from the medical records of the patient listed below. The reports may be released to other physicians or facilities participating in my care.
* I understand my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.
* I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS testing, psychiatric illness and alcohol or chemical abuse dependency will not be released unless I have given my specific consent to release this information.
* I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that this authorization will automatically expire on one year from date signed.
* I understand that a photocopy or facsimile of this authorization is as valid as the original.
* I authorize the release of any medical billing or other information necessary to process claims on my behalf.
* I agree to be fully responsible for all lawful debts incurred by myself (or dependents under care) for services received from Holistic Chiropractic and Wellness PLLC
* I understand that any verbal consent or intent to use photographs or social media network sharing by the patient or provider is protected as valid written consent when patient, other patient, or provider agreed on photographed educational testimonies.

_____
Signature of Patient

_____ _____
Printed Name Date

Please initial one box below:
If our office attempts to contact you and a message is taken by an answering machine/voicemail or another person, it is appropriate to leave a:
____ Detailed message regarding condition, appointments, or payments.
____ Message to call Round Rock Health & Wellness Center

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003
Revised According to New HIPAA Regulations September 23, 2013
Holistic Chiropractic and Wellness PLLC is committed to protecting your protected health information.
"Protected Health Information" (PHI) may include such items as: medical notes from your doctor, a claim from your provider listing your diagnosis, a medical treatment that you received, or laboratory/diagnostic test results. This notice about protecting your PHI is required by law. It tells you about your rights and how we use and disclose your health information.

YOUR HEALTH INFORMATION RIGHTS

- Request a restriction on certain uses and disclosures of your PHI; however, we are not required to approve your request.
- Request that we notify you about your PHI in a way or at a location that will help you keep your information confidential.
- Receive a list of certain disclosures we have made of your PHI. This is a list of disclosures made by us during a specified period of up to six years *except for disclosures made:*
    - For treatment, payment, and healthcare operations
    - For use in or related to a facility directory
    - To family members or friends involved in your care
    - To you directly
    - Pursuant to an authorization of you and your personal representative
    - For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes)
    - Before April 14, 2003
- In writing at any time, withdraw your permission for us to disclose your PHI, except for the information that we disclose before you stopped your permission.
- Review and obtain a copy of your own PHI.
- Ask us to change your PHI if you believe it is incorrect or incomplete. We may deny your request and, if so, will give you the reason(s) why the request was denied.
- Receive a paper or electronic copy of this Notice of Privacy Practices upon request.

HOW Holistic Chiropractic and Wellness PLLC MAY USE OR DISCLOSE YOUR PHI: The examples included with each category do not list every type of use or disclosure that may fall within that category. FOR TREATMENT: We may use and disclose your PHI to a physician or other healthcare provider providing treatment to you.
PAYMENT: We may use and disclose your PHI to obtain payment for services we provided to you. HEALTHCARE OPERATIONS: We may use and disclose your PHI in connection with chiropractic operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
REQUIREMENTS BY LAW: We may use and disclose your PHI when required to do so by law. We may also use or disclose your PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following:

- To prevent or control disease, injury or disability.
- To report disease, injury, birth or death.
- To report child abuse or neglect.
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA regulated products or activities.
- To locate and notify persons of recalls of products they may be using.
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease.
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

We may also use and disclose your PHI under certain circumstances for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency.
- To alert law enforcement of a death that we suspect was the result of criminal conduct.
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About a crime or suspected crime committed at the workplace.
- In response to a medical emergency not occurring at the workplace, if necessary to report a crime, including the nature of the crime, the locations of the crime or the victim, and the identity of the person who committed the crime.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your PHI to government health agencies for health oversight reasons, such as program audits or licensure reviews.
RESEARCH: We may use your PHI for approved research purposes, such as for study to cure a disease. SPECIAL GOVERNMENT FUNCTIONS: We may, such as protection of public officials or reporting to various branches of the armed services, require the use or disclosure of your PHI.
OTHER USES: We may use and disclose your PHI to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care.

OBLIGATIONS OF Holistic Chiropractic and Wellness PLLC

- Maintain the privacy of your PHI.
- Provide you with the Notice of its legal duties and privacy practices with respect to your PHI.
- Obtain your written authorization to use or disclose your PHI for reasons other than those listed in this Notice and permitted by law.
- Abide by the terms of this Notice that are currently in effect.
- Notify you if we are unable to agree to requested restriction on how your PHI is used or disclosed.
- Allow reasonable requests you may make to notify you about your PHI in a way or at a location that will help you keep your PHI confidential.

Holistic Chiropractic and Wellness PLLC reserves the right to change its information practices. The new provisions will be effective for all PHI that Holistic Chiropractic and Wellness PLLC maintains. Revised notices will be made available to you by written notices.

COMPLAINTS:
If you have a complaint about how Holistic Chiropractic and Wellness PLLC handles your PHI, or if you otherwise believe that your privacy rights have been violated by Holistic Chiropractic and Wellness PLLC , your complaint should be directed to:
Holistic Chiropractic and Wellness PLLC , 2251 Double Creek Dr, Suite #401 Round Rock, TX 78664 (512) 246-0220
Attention: Privacy Contact
If you are not satisfied with the manner in which Holistic Chiropractic and Wellness PLLC handles a complaint, you may submit a formal complaint to the U.S. Secretary of Health and Human Services in Washington, D.C. There will be no retaliation by Holistic Chiropractic and Wellness PLLC if you file a complaint.