CAMPBELLSBURG CHIROPRACTIC – DR. ALY WEBB
DOT PHYSICAL – INTAKE

Name: _____ **Date:** _____
Physical Address: _____
PO Box/Address 2: _____
City: _____ **State:** _____ **Zip:** _____

Social Security Number: _____

Phone Numbers: **Home:** _____
Cell: _____
Work: _____

Email: _____

Date of Birth: _____ **Age:** _____

Marital Status: **Married** _____ **Single** _____ **Divorced** _____
Child _____ **Widowed** _____

Employment Status: **Full Time** _____ **Part Time** _____ **Student** _____
Homemaker _____ **Retired** _____ **Disabled** _____
Unemployed _____

Occupation: _____

Employer: _____

License Class: _____

Vehicle to most likely be driven: _____

How did you learn about our DOT Physicals? _____

Emergency Contact: _____
Relationship: _____
Emergency Phone Number: _____

HIPAA PRIVACY

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing. Campbellsburg Chiropractic will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization, you acknowledge and agree that some of our treatments are performed at Campbellsburg Chiropractic in an open setting where incidental disclosures may occur. You also agree that Campbellsburg Chiropractic may use or disclose your personal health information for referral to other health care providers with your permission, any billing or collection activities or proceedings, leaving messages on answering machines or making phone calls to you regarding scheduling of appointments, your health benefit coverage and related discussion of your care, or phone or mail notifications of any internal office promotions.

Please identify the family members, friends or other persons who are or will be involved in your care or payment for health care and with whom you authorize us to share your protected health information:

Name	Relationship to you	List information to be shared
_____	_____	_____
_____	_____	_____
_____	_____	_____

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Campbellsburg Chiropractic's NOTICE OF PRIVACY PRACTICES containing a description of your rights, and permitted uses and disclosures, under HIPAA. While Campbellsburg Chiropractic has reserved the right to change the terms of its NOTICE OF PRIVACY PRACTICES, copies of the NOTICE, as amended, are available from Campbellsburg Chiropractic, at our office or by sending a written request with return address to Campbellsburg Chiropractic 8172 Main Street P.O. Box 293 Campbellsburg, KY 40011, Attn: Office Manager. You have the right to revoke this authorization, in writing, at any time, except to the extent that Campbellsburg Chiropractic, has taken action in reliance on it. A revocation is effective upon receipt by Campbellsburg Chiropractic, of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Campbellsburg Chiropractic, or (d) two (2) years from the date this authorization was executed.
By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

ACKNOWLEDGED AND AGREED TO BY:

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

OR

PRINT NAME OF PARENT/GUARDIAN OF MINOR: _____

PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP: _____

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #
_____
(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____ Gender: ○ M ○ F

E-mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ○ Yes ○ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ○ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ **Yes** ○ **No** ○ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ○ **Yes** ○ **No** ○ **Not Sure**

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures, epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)