Patient Contact Information

Title:	Last name:	Middle:	First:	Nickname:
Sex : Male / Female	Date of Birth:	Age:	Social Security#:	
Spouse's Name:	Do you have children? - Yes - No	Ages: _____ _____ _____ _____ _____		
Address:	City:	State:	Zip:	
Primary Phone:	Secondary Phone:	Mobile Phone:		
Home Email:	Work Email:	Preferred Language:		
Which email would you like us to use to communicate with you?	Home □	Work □	Which phone #?	Primary □ Secondary □ Mobile □

May we leave confidential (billing/medical condition/missed appointment) messages on your: Email - Yes - No Phone - Yes - No

Would you like to receive updates and messages/alerts via e-mail?	- Yes - No
Would you like us to send reports and updates to your Primary Care Physician?	- Yes - No
If Yes: Name:	Address:
Would you like us to send reports and updates to your Referring Physician?	- Yes - No
If Yes: Name:	Address:

Employment (circle one)	Employed	Self Employed	Retired	Student F/T	Student P/T	Other
Employer:	Occupation:					

Marital status (circle one)	Single	Married	Divorced	Widowed	In a relationship	Other	

Referred by:

Other family members seen here:

Primary Insurance Company Name	Policy Number	Group Number
Primary Insured if other than you:		
Secondary Insurance Company Name	Policy Number	Group Number
Secondary Insured if other than you:		

We need your written permission to share information about you with anyone else. If there is someone other than yourself that you would like us to be able to discuss your health or payment information with, please provide the following information. With whom may we share information about your general medical condition, diagnosis, test results, treatment plans or financial arrangements? This includes, but is not limited to general questions about your condition.

Name	Relationship	Phone # / Address

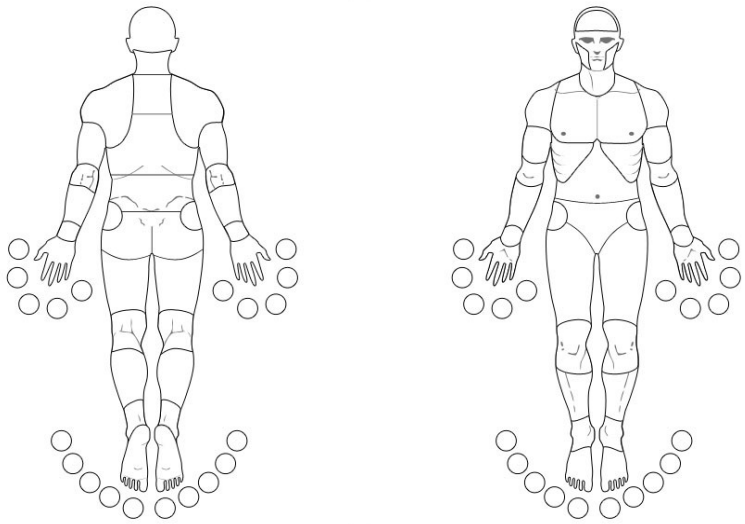
I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: _____ Date: _____

Current Complaints

Patient's Name: _____ Date: _____

Please indicate the current complaints you are experiencing by marking the image below and providing details using the sections below. If you have more than one region of complaints, use additional sheets.



Office Use Only	
Hgt: "	Respiration: bpm
Wgt lbs	R BP_____/_____ mm Hg
BMI	L BP_____/_____ mm Hg
Pulse: bpm	Right / Left Handed
Temperature F	
Regional Assessment	
NECK	BACK
LEFS	DASH

Area(s) of Complaint

Pain / Symptom Intensity:	**0 (None) 1 2 3 4 5 6 7 8 9 10 (Excruciating) N/A**
Mechanism Of Injury:	
Onset, When and how did the condition begin?	

Frequency (How Often?)	Infrequent < 25%	Occasional 25%-50%	Frequent 50% - 75%	Constant > 75%
Duration: How long?	____ seconds, minutes, hours, days, weeks, months, years over the past ____ days, weeks, months, year(s)			

When does it seem to be at its worse? (Timing)

☐ Morning ☐ Midday ☐ End of Day ☐ Throughout the day ☐ Night with Pain
During / After - ☐ Light ☐ Moderate ☐ Strenuous - Activities

Would you describe the pain as radiating/shooting?, If so where?

☐ Yes ☐ No

The symptoms are described as: (Quality)

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	

What makes it worse (Aggravating Factors)?

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking Up	Looking Down	Movement	Rest	Laying on back	Driving
Typing	Scooping	House Chores	Exercise	Laying on side	Stair Stepping

What makes it better? (Relieving Factors)

Sitting	Standing	Laying down	Knees bent up	Support
No Movement	Movement	Heat	Ice	Analgesic Topical
Stretching/Exercise	Medication	Rest	Massage	Adjustment

Comments:_____

_____

_____
Patient's Signature

Medical History for (print) :

Name of your family Doctor/Primary Care Physician:

What city and state?

Date of last Visit: / /

Date of last exam: / /

Past Surgeries (year of surgery):

Current Condition

The reason for this visit:

Have you been treated by a Medical Physician <u>for this condition</u>? - Yes - No
If so, who, when & where?

Have you ever been treated by a Chiropractor before? - Yes - No Was it for the current condition? - Yes - No
If so, who, when & where? .

Present/Past Illness /Conditions (ROS):

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ GE(Reflux)D
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐ Headaches
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Trouble Sleeping	☐ Stroke/TIA
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐ Polio

Details / Other :

Allergies:

Medications/Supplements	Dosage	Reason	Prescribed by	Date prescribed

Please use back of page if additional space is necessary.

Family History of Illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitis

Details / Other:

Patient Medical History, Continued

Social History:

Alcohol Consumption? - Yes - No ___drinks/week

Coffee Consumption? - Yes - No ___drinks/week

Soda pop Consumption? - Yes - No ___drinks/week

Water Consumption: ____ounces/day

Sleep Amount? ____hours/night

Pain Relievers? - Yes - No ____#per day OTC or Rx

Recreational Drug Use? - Yes - No

Healthy Eating Rank? (0-poor, 10 excellent)

0 1 2 3 4 5 6 7 8 9 10 N/A

Exercise Frequency: ____hours/day ____days/week

Physical Stress level? 0(none)-10(extreme)

0 1 2 3 4 5 6 7 8 9 10 N/A

Emotional Stress Level? 0(none)-10(extreme)

0 1 2 3 4 5 6 7 8 9 10 N/A

Major Stressors:

Things to Improve:

Other Health Goals:

Smoking History

Currently Smoke? - Yes - No

Smoked in Past: - Yes - No Date Quit ___/___/____

Years Smoked? _____years

Packs Per Day? _____

Level of Interest in Quitting 0 (none)- 10 (extreme)

0 1 2 3 4 5 6 7 8 9 10 N/A

Comments on Smoking?

Comments:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name (Printed): _____

Patient Signature: _____ Date:_____

...FeelBetter...Naturally.

NOTICE OF PATIENT PRIVACY PRACTICES

This notice has been published by Montpelier Family Chiropractic. It applies to everyone who works for Montpelier Family Chiropractic, including our employees, contractors, and volunteers.

The Montpelier Family Chiropractic team understands that information about you and your health is sensitive and personal. We are also required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This notice is intended to let you know how we use and disclose your information.

This notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and copy our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we have made about you.

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the news effective for all information to which this Notice applies. This Notice will be in effect from May 23, 2005 until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you by sending a copy to you at your last address shown in our records. We will also publish the amended Notice in our office.

This Notice covers all information in our written or electronic records which concern you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, submit insurance claims on your behalf, or manage some of our administrative options.

Except for certain disclosures for legal purposes described below, we can only use or disclose information about you with your written authorization or consent.

With your written consent, we can use or disclose our information for the following purposes:

- We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students, or other individuals who work in our practices who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.
- We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We also disclose such information to your health plan or other third party financially responsible for your care or to claims and billing services if necessary.
- We may use or disclose information about you for operational activities in connection with our practices. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

Without your consent or authorization, we may disclose information about you only for the following purposes:

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, which your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harms to you or others. To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation, subject to certain requirements controlling the terms or disclosures.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- For medical research purposes, subject to your authorization or approval by an institutional review board.
- If you are in the United States military, national security or intelligence, or foreign service, to your authorized federal officials.

We may not use or disclose information about you for any other purpose without your written authorizations, provided separately from you in written consent.

By law, you are entitled to:

- Ask us to further restrict our use and disclosure of information about you. We are not required to grant such a request, but if we do we must make sure restrictions are implemented.
- Receive confidential communications from us, at an alternative address you provide to us.
- Review our records for your information.
- Obtain a copy of all or any part of our records of your information. We may charge you a reasonable copying charge of $15.00 plus .75 cents per page for the first 30 pages then .50 cents per each additional page.
- Ask us to amend your records, if you believe that they are incorrect or incomplete. We are not required to make such an amendment. If you request an amendment and we determine we will not make it, you are entitled to have a statement of your disagreement included in your records. If you do include a statement of disagreement in your records, we may include a statement of explanation or response in your records as well.
- Obtain an accounting of all persons to who have disclosed information about you, for any purposes except your treatment, payment for your treatment or our health care operations.
- If you have provided us with an authorization for any purpose, you may revoke it an any time. You may revoke an authorization by giving us written notice at our Contact address given above. Your revocation will be effective as of the time we receive it, and will not apply to any uses or disclosures which occur before that time.
- You may revoke your consent to uses and disclosures for treatment, payment, and health care operations purposes at any time. You may revoke your consent by giving us written notice at our contact address given above. Your revocation will be effective as of the time we receive it, and will not apply to any uses of disclosures which occur before the time. If you revoke your consent, we may elect to discontinue your health care treatment.
- If you believe we have violated your privacy rights, you may forward us a written complaint to our contact address given above. You may also file a complaint with the Secretary of the United States Department of Health and Human Services. If you do file a complaint, we are legally prohibited from retaliating against you.

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services; and
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my medical provider's *Notice of Privacy Practices* containing a more complete description of the use and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my medical provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then are bound to abide by such restrictions.

Patient name_____

Signature_____

Relationship to patient_____

Date_____

Montpelier Family Chiropractic

...Feel Better...Naturally.

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctors will use their 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 soft tissue mobilization may also be used. Passive and active exercise will also be utilized in most cases as they progress.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, 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. The 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:

- *Self Care including 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 multitude of undesirable side effects and patient dependence in a significant number of cases.
- *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 skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

PATIENT:

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

WITNESS:

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