

Patient Name: _____ Date: _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email Address: _____

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

Social Security # _____

Occupation _____
Employer _____

Emergency Contact and Phone Number: _____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

1. Reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

3. Past Health History:

A. Please indicate if you have a history of any of the following:

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems
- Lung problems/shortness of breath Cancer Diabetes Psychiatric disorders
- Bipolar disorder Major depression Schizophrenia Stroke/TIA's Other _____
- None of the above

B. Previous Injury or Trauma:

Have you ever broken any bones? Which?

C. Allergies: _____

Patient Name: _____ Date: _____

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease Diabetes
- Other _____ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death	Age at death

Social and Occupational History:

- A. Job description:**

- B. Work schedule:**

- C. Recreational activities:**

- D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

Patient Name: _____

Date: _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing
- COPD
- Emphysema
- Other _____
- None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries
- Congestive heart failure
- Murmurs or valvular disease
- Heart attacks/MIs
- Heart disease/problems
- Hypertension
- Pacemaker
- Angina/chest pain
- Irregular heartbeat
- Other _____
- None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision
- One-sided weakness of face or body
- History of seizures
- One-sided decreased feeling in the face or body
- Headaches
- Memory loss
- Tremors
- Vertigo
- Loss of sense of smell
- Strokes/TIAs
- Other _____
- None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease
- Hormone replacement therapy
- Injectable steroid replacements
- Diabetes
- Other _____
- None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones
- Hematuria (blood in the urine)
- Incontinence (can't control)
- Bladder Infections
- Difficulty urinating
- Kidney disease
- Dialysis
- Other _____
- None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea
- Difficulty swallowing
- Ulcerative disease
- Frequent abdominal pain
- Hiatal hernia
- Constipation
- Pancreatic disease
- Irritable bowel/colitis
- Hepatitis or liver disease
- Bloody or black tarry stools
- Vomiting blood
- Bowel incontinence
- Gastroesophageal reflux/heartburn
- Other _____
- None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia
- Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
- HIV positive
- Abnormal bleeding/bruising
- Sickle-cell anemia
- Enlarged lymph nodes
- Hemophilia
- Hypercoagulation or deep venous thrombosis/history of blood clots
- Anticoagulant therapy
- Regular aspirin use
- Other _____
- None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns
- Significant rashes
- Skin grafts
- Psoriatic disorders
- Other _____
- None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis
- Gout
- Osteoarthritis
- Broken bones
- Spinal fracture
- Spinal surgery
- Joint surgery
- Arthritis (unknown type)
- Scoliosis
- Metal implants
- Other _____
- None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis
- Depression
- Suicidal ideations
- Bipolar disorder
- Homicidal ideations
- Schizophrenia
- Psychiatric hospitalizations
- Other _____
- None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to [Name of Doctor/Office] for services performed.

Patient or Guardian Signature _____

Date _____

Patient Name: _____

Date: _____

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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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 health care 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 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, marketing, and fund raising activities, and conduction 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 included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you 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 AND 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.

Signature of Patient or Representative

Date

Printed Name



Northtown Chiropractic & Injury Rehab

Consent for Purposes of Treatment, Payment, & Healthcare Operations

I consent to the use or disclosure of my protected health information by Northtown Chiropractic & Injury Rehab LLP for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations. I understand that analysis, diagnosis, or treatment of me by Northtown Chiropractic & Injury Rehab LLP may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that Northtown Chiropractic & Injury Rehab LLP has taken in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have read the Notice of Privacy Practices of Northtown Chiropractic & Injury Rehab LLP and understand that I have a right to review the Notice of Privacy Practices before signing this document. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of Northtown Chiropractic & Injury Rehab LLP.

Northtown Chiropractic & Injury Rehab LLP reserves the right to change the privacy practices that are described with proper notice.

Patient understands that our practice works out-of-network with insurance companies. All fees are due at time of service. A patient can submit receipts to their insurance company for possible direct reimbursement, depending on their particular plan.

*Northtown Chiropractic services are not covered by Medicare or Medicaid

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There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely rare;
- c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Name: _____ Date: _____

Signature: _____

I consent to disclose my personal information to the following:

Northtown Chiropractic & Injury Rehab LLP

6221 Transit Road

East Amherst, NY 14051

(716) 810-9329

www.northtownchiro.com