

# CHIROPRACTIC INTAKE & HISTORY



<b>PATIENT INFORMATION</b>	Patient #: _____	Date: _____
Patient Name _____ <small style="margin-left: 150px;">LAST NAME</small>	Employer / School _____	
Address _____ <small style="margin-left: 50px;">FIRST NAME</small> <small style="margin-left: 100px;">Preferred Nickname</small>	Occupation _____	
City _____ State _____ Zip _____	Spouse's Name _____	
Home Phone _____	Children's Names & Ages _____	
Cell Phone _____	Children's health concerns? _____	
Email _____		
Sex <input type="checkbox"/> M <input type="checkbox"/> F      Age: _____      Date of Birth: _____	Are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, I am due _____	
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor	Have you seen a chiropractor before? <input type="checkbox"/> No <input type="checkbox"/> Yes, when? _____	
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered	<b>Who may we thank for referring you?</b> _____	

## HOW CAN WE HELP YOU?

<u>Health Concerns:</u> List according to severity	<u>Rate of Severity</u> 1=Mild 10=Unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	How often do you have these symptoms?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

Please mark the areas on the diagram with the following letters to describe your symptoms:

What does it feel like?

- N=** Numbness/Tingling
- T=** Tight/Stiff
- D=** Dull
- A=** Aching
- C=** Cramping
- S=** Sharp/Stabbing/Shooting
- B=** Burning
- Other \_\_\_\_\_

## IMPACT OF YOUR SYMPTOMS

How are your health concerns interfering with your life? (Check where appropriate.)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## PATIENT WELLNESS ASSESSMENT

### What are your health goals?

IMMEDIATE \_\_\_\_\_

SHORT TERM \_\_\_\_\_

LONG TERM \_\_\_\_\_

### How committed are you to correcting this issue? (Please circle.)

0
1
2
3
4
5
6
7
8
9
10

NOT COMMITTED VERY COMMITTED

## HISTORY OF PHYSICAL TRAUMA

Please list past surgeries, adult & childhood injuries, and/or motor vehicle accidents.

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## HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD  | <input type="checkbox"/> Childhood Illness                                    | <input type="checkbox"/> Headaches / Migraines                                  | <input type="checkbox"/> Ringing in Ears/Earaches |
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Depression   | <input type="checkbox"/> Heartburn  | <input type="checkbox"/> Scoliosis                |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Hip Issues   | <input type="checkbox"/> Sinus Issues             |
| <input type="checkbox"/> Asthma/Allergies  | <input type="checkbox"/> Digestive Issues<br>(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues  | <input type="checkbox"/> Shoulder Issues          |
| <input type="checkbox"/> Back Pain   | <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Lymphatic Issues                                       | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Cardiovascular Issues<br>(Heart disease, high blood pressure/cholesterol) | <input type="checkbox"/> Elbow/Wrist/Hand Issues                              | <input type="checkbox"/> Neurologic Issues                                      | <input type="checkbox"/> TMJ Issues               |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Endocrine Issues (Thyroid)                           | <input type="checkbox"/> Neck Pain  | <input type="checkbox"/> Urinary Issues           |
| <input type="checkbox"/> Circulation Issues  | <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Reproductive Issues<br>(Menstrual irregular/Fertility) | <input type="checkbox"/> Osteoporosis             |
|  | <input type="checkbox"/> Foot/Ankle Issues                                    |   | <input type="checkbox"/> Other _____              |

## ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

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MEDICATIONS (list)

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SUPPLEMENTS (list)

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# HIPAA Notice of Privacy Practices

Meininger Family Chiropractic  
33 Lyman St. Suite 108  
Westborough, MA 01581  
(508) 898-2228

**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 condition and related health care services.

## **1. 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 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 disclosure 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 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.

## **2. Your Rights**

**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 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 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 not 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.

## **3. 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 **March 14<sup>th</sup>, 2007.**

We are required 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.

# Notice of Privacy Practices

We are concerned with protecting your privacy especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policy and procedures. We encourage you to read this document for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal information, we would be happy to address them.

I have received a copy of the HIPAA for Meininger Family Chiropractic.

\_\_\_\_\_  
Signature

\_\_\_/\_\_\_/\_\_\_  
Date

## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understands both the objective and the method that will be used to attain it.

**Adjustment** – An adjustment is the specific application of forces that facilitate the body’s correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Subluxation** – A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body’s innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. *Our only practice objective is to eliminate a major interference to the expression of the body’s innate wisdom.* Our only method is specific **adjustments** to correct vertebral subluxations.

I understand that I have the right to have all of my questions pertaining to the purpose of chiropractic care answered to my complete satisfaction prior to my first adjustment. I therefore accept any and all chiropractic adjustments on this basis.

If the patient is under the age of 18, I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

\_\_\_\_\_  
Signature (Parent/Guardian if under 18)

\_\_\_/\_\_\_/\_\_\_  
Date