Required for Your Case History File: All Information Is Confidential

Full Legal Name____________________________________ Name you prefer________________

Mailing Address____

City___________________________________ State____________ Zip Code_________________

Telephone (Home) _____________________ Telephone (Work) __________________________

Email _______________________________ Referred by__________________________________

Occupation_____________________________ Employer____________________________________

Name of Spouse____Number of Children__________

Emergency Contact ___________________________________Telephone_____________________

Age_________ Date of Birth _____________ Sex __________ Years of Education____________

Circle one: Married Single Widowed Divorced Separated

Past chiropractic care? Yes ❑ No ❑ If yes, who? ____

Who is your primary care physician? ____
Date of Last Physical Examination__________________

Have you been treated for any health condition by a physician in the last year? Yes ❑ No ❑

What medications/vitamins/herbs are you taking?____
____
____Are you allergic to any medications? Yes ❑ No ❑

Previous serious illness/ hospitalization: (Please date & describe) _________________________
____

Have ever had: Surgery Yes ❑ No ❑ Fractures Yes ❑ No ❑ Car Accidents Yes ❑ No ❑
Falls Yes ❑ No ❑ On-Job Injury Yes ❑ No ❑

Family history of: Heart disease Yes ❑ No ❑ Cancer Yes ❑ No ❑ Diabetes Yes ❑ No ❑

If you are female, are you possibly pregnant? Yes ❑ No ❑ Date of last menstrual period ____

Primary Symptom/Problem for this visit ____
____

Have you been prescribed an opioid for your primary problem? Yes ❐ No ❐
Have you had a previous surgery for your primary problem? Yes ❐ No ❐
Are you considering surgery for your primary problem? Yes ❐ No ❐
Have you had a previous steroid injection for your primary problem? Yes ❐ No ❐
Are you considering a steroid injection for your primary problem? Yes ❐ No ❐

Date symptoms first began ____

How did your symptoms first begin? ____

Other Symptoms ____

Pains is: Constant ❑ Intermittent ❑ Is your condition getting? Worse ❑ Better ❑ Same ❑

What activities aggravate your condition?____

What activities lessen your symptoms? ____

Is condition worse during certain times of the day?____________________________________

Is this condition interfering with work? Yes ❑ No ❑ sleep? Yes ❑ No ❑ routine? Yes ❑ No ❑

Other doctors seen for this condition ____

List home remedies tried ____

Do you have any of the following?

Constitutional
___ Unexplained Weight Loss
___ Fatigue or Weakness
___Fever

Eyes
___Glaucoma
___Cataracts
___Double Vision

Ears, Nose, Throat
___ Difficulty Hearing
___Buzzing or Ringing in Ears
___Dizziness
___ Loss of Smell
___Sinus Trouble
___ Difficulty Swallowing
___Loss of Taste

Skin
___Rashes
___Hives
___Itching

Allergic/Immunologic
___Hives/Hay Fever

Respiratory
___Cold/Flu/Cough
___Coughing Blood
___Wheezing

Gastrointestinal
___Nausea or Vomiting
___Constipation
___Diarrhea
___Digestive Problems

Genitourinary
___Blood in Urine
___Bladder Leakage
___Burning/Frequent Urination

Musculoskeletal
___Spinal Pain
___Joint Swelling
___Joint Stiffness

Cardiovascular
___Chest Pain
___Shortness of Breath
___Racing Heartbeat
___Fainting Spells

Neurological
___Headaches
___Memory Loss
___Tremors
___Numbness
___Loss of Strength
___Seizures

Mental Status
___Anxiety/Depression
___Mood Swings
___Difficult Sleeping
___Stress

Endocrine
___Loss of Hair
___Heat/Cold Intolerance
___Diabetes
___Excessive Sweating
___Change in Appetite

Hematologic/Lymphatic
___Ease of bruising
___Gums Bleed Easily
___Enlarged Glands

Check if you have had any of the following symptoms in the last 30 days:

Pain worse at night ❑ Constant pain unrelated to motion ❑ Unexplained weight loss ❑
Loss of bowel or bladder control ❑ Bacterial infection ❑ Surgery ❑ Fever or chills ❑

Check if you have ever had any of the following:

History of Cancer ❑ History of HIV ❑ Use of Steroids ❑ Use of IV Drugs ❑ Blood Transfusions ❑

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information you deem appropriate to any insurance company.

Signature ______________________________________Date _________________form 105 a

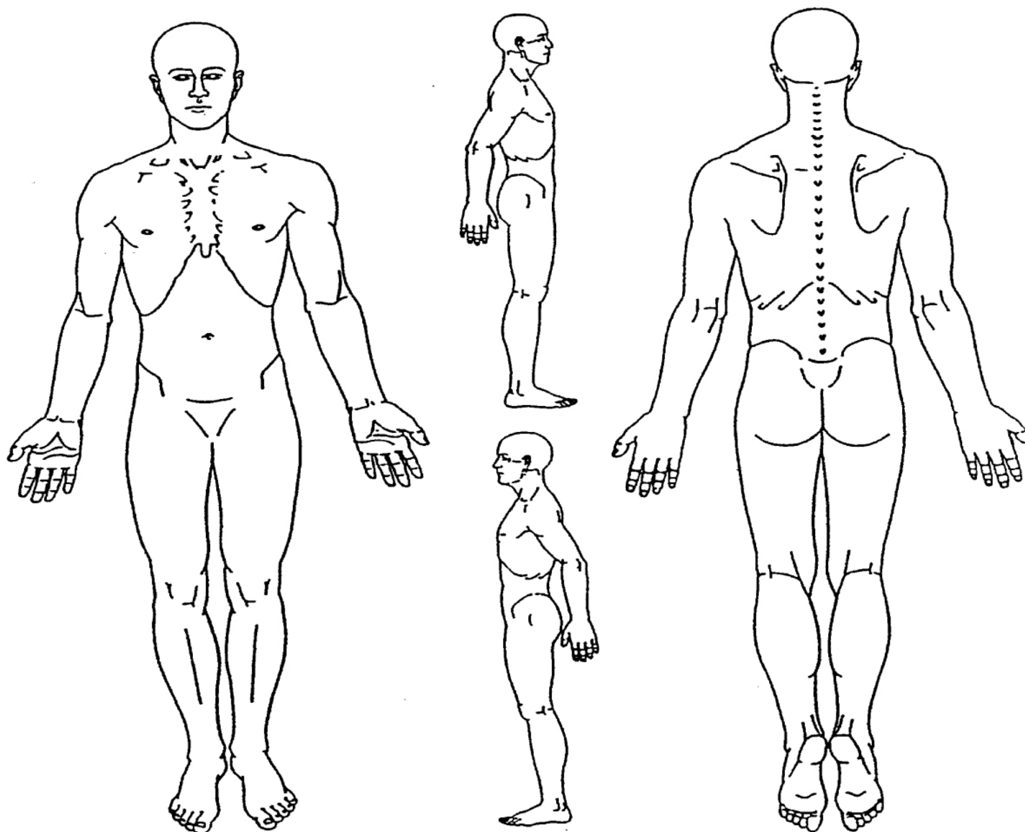
PATIENT ______________________________ **Family Health History** DATE _________________________

Relation	Age	First Name Only	If Deceased Cause of Death	Age At Death	State of Health
Father					
Mother					
Husband or wife					
Brothers and Sisters					
Children					
Others					

form 106

Where is your pain now? Mark the areas where you feel sensations using the appropriate symbols. Please mark an X on the area where the pain is now worst.

Aching	Numbness	Pins and Needles	Burning	Sharp/stabbing	Stiff/tight
yyyyy	= = =	oooo	zzzz	/////	***



How bad is your pain? On the scale below circle your pain.

Right now............ No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
On average........... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
At its very worst... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Overall, is your pain generally: improving ❑ same ❑ worsening ❑

Name ________________________________ Date______________

form 102

Pain Medication Index

Please tell us about your pain medication(s).
How many pain pills have you taken in the last 24 hours?

Name ___________________________________ Date ____________

Name of Non-Prescription Pain Medication ___________________________________
number of pills _______ mg ______ total mg/d _______

Name of Non-Prescription Pain Medication ___________________________________
number of pills _______ mg ______ total mg/d _______

Name of Non-Prescription Pain Medication ___________________________________
number of pills _______ mg ______ total mg/d _______

Name of Prescription Pain Medication _______________________________________
number of pills _______ mg ______ total mg/d _______

Name of Prescription Pain Medication _______________________________________
number of pills _______ mg ______ total mg/d _______

Name of Prescription Pain Medication _______________________________________
number of pills _______ mg ______ total mg/d _______

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Quadruple Visual Analog Scale (QVAS)

Patient's Name:_______________________________________ Date:____________________________

Instructions: Please circle **<u>ONE NUMBER</u>** that best describes the question being asked. *Remember, a low number means there is less pain; a higher number means there is more pain.*

The pain I am rating is: (Brief description, "Back Pain", "Neck Pain", etc.)

____

1 – Rate your pain RIGHT NOW

No Pain____Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2 – Rate your TYPICAL OR AVERAGE pain

No Pain____Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

3 – Rate your pain AT ITS WORST (how close to a "10" does your pain get?)

No pain____Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

4 – Rate your pain AT ITS BEST (how close to a "0" does your pain get?)

No Pain____Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Score:

____

Examiner

To calculate Outcome Assessment Tool Score (OATS), add first three numbers, divide by 3 and multiply by 10.

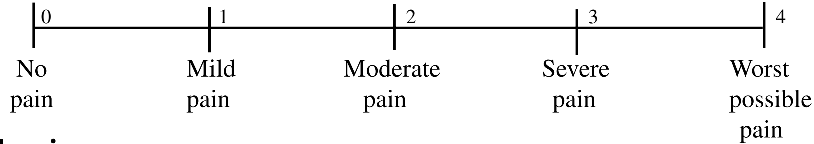
This form is an adaption of "Quadruple Visual Analogue Scale" *reprinted from* Spine, 18, *Von Korff M, Reyo RA, Sherkin D, Barlow SF*, Back Pain in primary care: Outcomes at 1 year, 855 862, 1993, with permission from Elsevier Science.

Functional Rating Index

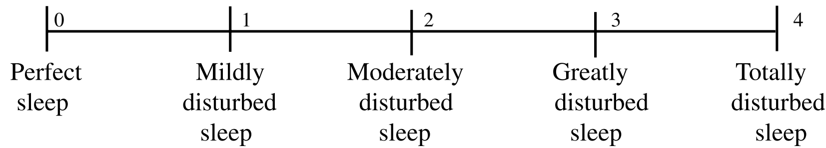
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

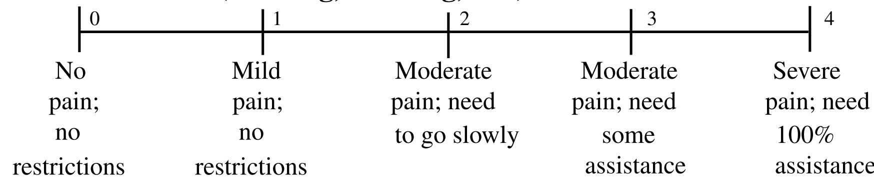
1. Pain Intensity



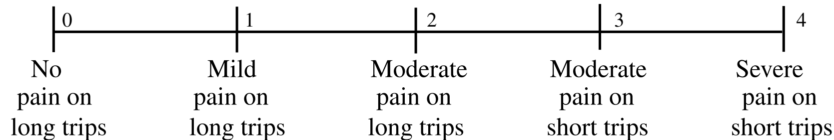
2. Sleeping



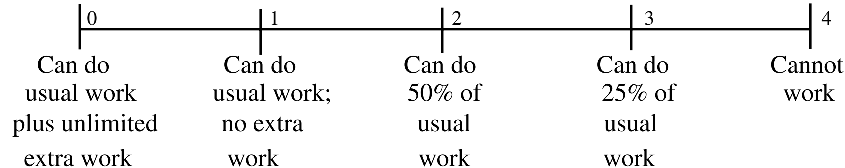
3. Personal Care (washing, dressing, etc.)



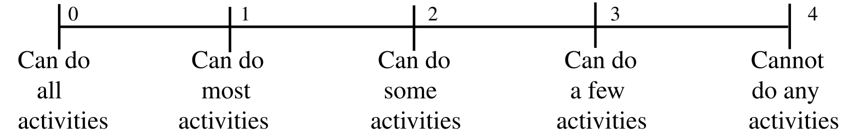
4. Travel (driving, etc.)



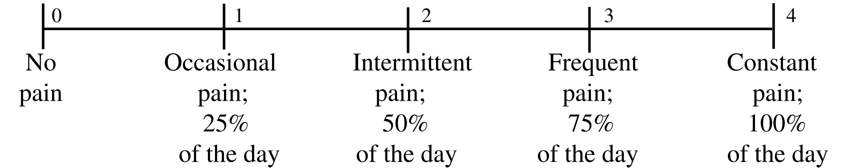
5. Work



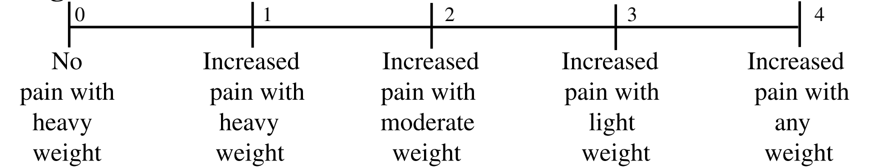
6. Recreation



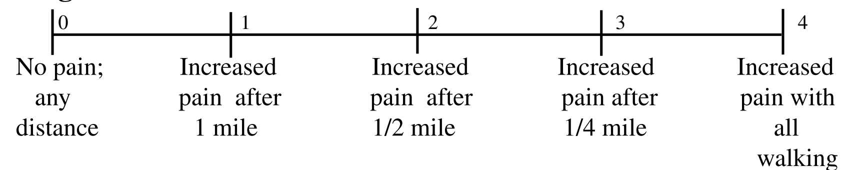
7. Frequency of pain



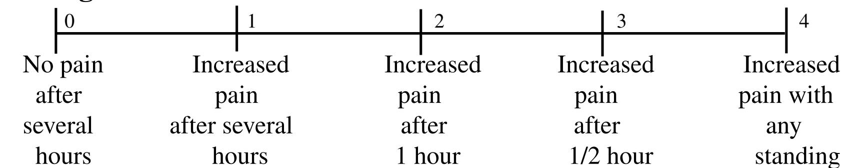
8. Lifting



9. Walking



10. Standing



Name ______________________________
PRINTED

Total Score __________

____
Signature

____
Date

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www.chiroevidence.com

Atlantic Chiropractic and Rehab
Notice of Privacy Practices

We Are Committed To Protecting Your Medical Information.

Under Federal Law, we are required to:

• Protect the privacy of your protected health information.
• Provide you with this Notice of Privacy Practices.
• Follow the practices and procedures set forth in the Notice.

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. If you have any questions about this Notice, please contact our Privacy Officer, Dr. Christina Saracina.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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 both your medical records and personal information such as your name, social security number, address, and phone number. We may change the terms of our notice at any time. Upon your request, we will provide you with the revised Notice of Privacy Practices.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In accordance with this Notice, and without asking for your express consent or authorization, this clinic may use and disclose your protected health information for treatment, payment or healthcare operations. For example:

Treatment: Your protected health information may be used and disclosed by us (doctor and office staff) and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. This includes another physician who may be treating you or a physician to whom you have been referred (eg., a specialist or laboratory).

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services from a third party, either directly or through a billing service. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose your protected health information, as needed, in order to support the operations of this clinic. These activities include, but are

not limited to, quality assessment activities, employee review activities, and conducting or arranging for other activities.

For example, 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 by a postcard mailed to the address provided by you and/or telephoning your home and leaving a message on your answering machine or with the individual answering the phone. We may send you birthday greetings by e-mail.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use your de-identified medical information (information that cannot be used to identify you) to assess where we can make improvements in the care and services we offer.

We will share your protected health information with third party "business associates" that perform various activities for the practice (e.g., billing, transcription services). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Others Involved in Your Healthcare: We may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgment.

OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES

We may use and disclose your protected health information without asking for your express consent or authorization in the following instances:

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. In this event, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you, but is unable to do so due to substantial communication barriers, and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products, enable product recalls, make repairs or replacements, or conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and, in certain conditions, in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose protected health information for law enforcement purposes, so long as applicable legal requirements are met.

Coroners, Funeral Directors and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out its duties. We may disclose protected health information to your designated personal representative upon your death.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us in order to comply with workers' compensation laws and other similar legally established programs.

De-identified Information. We may use and disclose health information that may be related to your care, but does not identify you and cannot be used to identify you.

Personal Representative. We may use and disclose protected health information to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Required Uses and Disclosures: Under the law, we must make disclosures to you and, when requested, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Authorization

Uses and/or disclosures, other than those described above, will be made only with your written authorization, unless otherwise permitted or required by law elsewhere:

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to revoke any authorization you have given to us, at any time. To do so, you must submit a request in writing to our Privacy Officer.

You have the right to inspect and copy your protected health information. You may inspect and obtain a copy of protected health information about you that is contained in our files for as long as we maintain the protected health information. Under federal law, however, you may not inspect or copy certain records. However, in some circumstances, you may have a right to have a decision to deny access reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. Your written request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction you may request, but if we do, we will abide by our agreement (except in an emergency).

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We will not request an explanation from you for the basis of the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. In certain cases, we may deny your request for an amendment. 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. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. A patient's request must state a time period not to exceed six years. The right to receive this information is subject to certain exceptions, restrictions and limitations. We will fulfill one request per 12-month period free of charge.

You have the right to request that your physician transmit your protected health information to a designated party. Upon your signed written request we will send your protected health information to a designated third party.

Out-of-Pocket-Payments. If you paid out-of-pocket in full for a specific item or service and you have requested that we not bill your health plan, you have the right to ask that your protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Immunizations. We will disclose immunization data to schools if a patient's legal representative agrees to the disclosure.

Right to get notice of a breach. You have the right to receive written notification if the practice discovers a breach of your unsecured protected health information and determines through a risk assessment that notification is required.

The following uses and disclosures of your protected health information will be made only with your written authorization:
1. Uses and disclosures of protected health information for marketing purposes and fundraising communications; and
2. Disclosures that constitute a sale of your protected health information.

Right to an Electronic Copy of Electronic Medical Records. If your protected health information is maintained in an electronic format, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health information in the form or format you request, if it is readily producible in such form or format. If the protected health information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or a readable hard copy form. We may charge you a reasonable, cost-based fee associated with transmitting the electronic medical record.

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 Officer in writing. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, for further information about the complaint process.

form 100a

Atlantic Chiropractic and Rehab
Acknowledgement of Receipt of Notice

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this clinic's Notice of Privacy Practices which has an effective date of September 1, 2013.

Patient Name (print) ____

Patient Signature ____

Date ___________________

If signed by someone other than the patient, please indicate:

Relationship:
- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ other (specify)

For Office Use Only

Photo ID Date ________________________ Initial ____________________

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

Signature of witness ______________________________

Printed name of witness ______________________________

Date _________________________________