CHIROPRACTIC INTAKE & HISTORY

Name _____ Date _____

PATIENT INFORMATION

Patient Name _____
LAST NAME

_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State & Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age ___ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Who may we thank for referring you? _____

Employer / School _____

Occupation _____

Spouse's/Partner's Name _____

Spouse's/Partner's Employer/Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

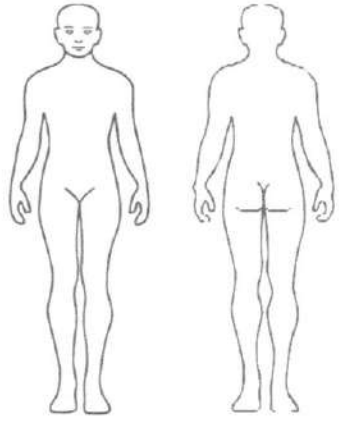
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

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

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

South Shore Family Chiropractic
33 Sea Street, Weymouth, MA 02191
Office: (781) 335-7671

Dr. William M. Byrnes: Director
Dr. Amy Hall-Newman
www.ssfamily.com email: info@ssfamily.com

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands to perform an adjustment in order to realign your vertebrate. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may also feel movement of the joint.
Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. A minority of patients may notice muscle stiffness or soreness after the first few days of adjustments similar to after a new workout. Rare complications, while extremely unlikely, can include fracture, ligamentous sprain, or injury to intervertebral discs. These complications are only seen with an inherent weakness in the body already present and our exam process is designed to pick up these red flags.
Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as very rare, about as often as complications are seen from taking a single aspirin tablet.
Other Treatment Options: No other profession is trained to find and correct your subluxations.
Risks of Remaining Untreated: Delay of treatment allows degenerative changes to continue, and these changes can further reduce skeletal mobility and increase nerve irritation. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.
No Warranty: I understand that my doctor at South Shore Family Chiropractic cannot make any promises or guarantees regarding improvement in my condition. I understand that my doctor will share with me his/her opinion regarding potential results from chiropractic care and will discuss treatment options with me. I have read the explanation above of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of chiropractic care. I have freely decided to undergo the recommended care plan, and hereby give my full consent to receive chiropractic care.

Printed Name _____ Signature _____ Date _____

Consent to Treat Minor – For use when applicable I hereby authorize South Shore Family Chiropractic Doctors of Chiropractic, to administer chiropractic care, as deemed necessary, to my child.

Printed Name _____ Signature _____ Date _____

Privacy Policy Acknowledgement/Assignment and Release

Patient Acknowledgement:

I acknowledge that I have read/received a copy of South Shore Family Chiropractic's Notice of Privacy Practices in accordance with federal regulations dictated by the Health Insurance Portability and Accountability Act (HIPA).

Printed Name/For Minors: Parent Guardian _____ Signature _____ Date _____

Assignment and Release: *I hereby authorize and direct my insurance benefits to be paid directly to South Shore Family Chiropractic and understand I am financially responsible for all non-covered services provided by South Shore Family Chiropractic.*

Printed Name/For Minors: Parent Guardian _____ Signature _____ Date _____

GUARANTOR NAME & ADDRESS - Person to Bill if Other Than Patient

Terms of Acceptance

When a patient seeks Chiropractic care and when a Chiropractor accepts a patient for such care, it is essential that they both be seeking the same goals.

It is not the goal of this office to treat, nor cure physical, mental, or emotional ailments; nor to diagnose or give advice about such ailments.

Our only goal and intention is to keep the body as free from vertebral subluxations as we can. We do this because of our absolute conviction that every human being functions better on all levels when no subluxations are present.

If at any time your care lapses for 6 months or longer and you choose to re-activate, you will be welcomed into our office once again as a new patient following our new patient protocol.

I _____ undertake Chiropractic Care in the office on the understanding of and in agreement with the above explanation.

_____	_____	_____
Print Name/For Minors: Parent/Guardian	Signed	Date

Congratulations on choosing Chiropractic. Follow through with your family and enjoy the health benefits that come with a Chiropractic lifestyle.

HIPPA: Health Insurance Portability & Accountability Act: Notices of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully. 164.528

Introduction: At SSFC, we are committed to creating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective immediately and applies to all protected health information as defined by federal regulations.

Understanding your Health Record/Information: Each time you visit SSFC, a record of your visit is made. Typically, this record contains symptoms, examination, and test results, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record serves as a basis for planning your care and treatment, means of communication among many health professionals who contribute to your care, legal document describing the care you received, means by when you or a third-party payer can verify that services billed were provided. A tool in educating health professionals and a source of information for public health officials charged with improving the health of the state and the nation. A source of data for our planning and marketing, a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights: Although your health record is the physical property of SSFC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect a copy of your health record as provided in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.524
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.524
- Request communications of your health information by alternative means at alternative locations
- Request a restriction on certain uses of your information as provided by 45 CFR 164.524
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities: SSFC is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post these changes in our office. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem: If you have any questions and would like additional information, you may contact the practice's Privacy Officer, Lori Byrnes at 781-335-7671. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, Lori Byrnes or with the office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The online address for the OCR is: https://www.mass.gov/how-to/file-a-civil-rights-complaint

Examples of Disclosures for Treatment, Payment and Health Operations: We will use your health information for treatment. We will use your information for payment. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to Worker's Compensation or other similar programs established by law. As required by law, we may disclose your health information to Public Health or legal authorities charged with preventing or controlling disease, injury, or disability. We may disclose health information to Law enforcement purposed as required by law or in a response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Personnel Records: It shall be the policy of SSFC to allow the following staff into the Secondary Personnel Records of Employees: Doctor of Chiropractic, Covering Chiropractor, Office Manager, Privacy Manager.

South Shore Family Chiropractic:

Dr. William M. Byrnes *Director*
33 Sea Street, Weymouth, MA 02191
****
Office: 781-335-7671 Fax: 781-335-7856

Workers Compensation

Patient Name/Address/Phone/DOB: _____

_____

_____

_____

Claim #: _____

Date of Injury: _____

Employer Name: _____

Human Resource Name/Phone/Fax: _____

_____

Utilization Review Name/Phone/Fax: _____

_____

Workers Comp Name/Phone/Fax/Bills Address: _____

_____

_____

_____

Patient Health Insurance Company/ID#: _____

WORKER'S COMPENSATION QUESTIONAIRE

Injuries Involving Lifting-

From where were you lifting the object? _____

How many pounds was the object you were lifting? _____

What position were you in while lifting the object?_____

What type of pain did you feel immediately after the injury? _____

Injuries Involving Falling-

Where at work did you fall? _____

What part of your body did you land on?_____

What other areas were you injured as a result of your fall? _____

_____

Job Analysis-

What regular activities do you perform at your job?_____

_____

How much do you regularly lift at your job?_____

Are you required to regularly bend over while lifting at your job?_____

Are your hands subject to repetitive movements?_____Such as?_____

_____

How many hours are your required to regularly perform each of the following activities at your job?

Sitting:_____

Standing:_____

Walking:_____

Lifting:_____

Other Work Related Injuries(If not caused by lifting or falling)-

_____

_____

_____

_____