Personal Information

Date _____

Name _____ **Age**_____ **D.O.B.**_____

Home Address_____
City State Zip

Mailing Address_____
(If Different From Home Address) City State Zip

Local Address_____
(If Student) City State Zip

Social Security Number _____

Home Phone _____

Cell Phone _____

Work Phone _____

E-mail _____

Occupation _____ **Employer** _____

Emergency Contact Name _____

Work Phone _____ **Cell Phone** _____

Spouse Name _____

How did you hear about us? _____

MEDICAL HISTORY FORM

Name: _____ **Age:** _____ **Date of Birth:** _____ **Date:** _____

I. PAST MEDICAL HISTORY

a. Surgeries

i. Type: _____ Date: _____
ii. Type: _____ Date: _____
iii. Type: _____ Date: _____

b. Fractures

i. Type: _____ Date: _____
ii. Type: _____ Date: _____
iii. Type: _____ Date: _____

c. ER Visits

i. Type: _____ Date: _____
ii. Type: _____ Date: _____
iii. Type: _____ Date: _____

II. FAMILY HISTORY

a. Mother: Age *(if living)* _____ Age *(at death)* _____ Cause of death _____
List any medical problems she had or lived with: _____

b. Father: Age *(if living)* _____ Age *(at death)* _____ Cause of death _____
List any medical problems he had or lived with: _____

III. LIFESTYLE HISTORY

a. Have you ever been pregnant? Yes ❑ No ❑ N/A ❑
If yes, how many births? _____ Cesarean Birth? Yes ❑ No ❑ *Any complications:* _____
b. Smoking Status: ❑ Every Day ❑ Former Smoker ❑ Never Smoked ❑ Heavy Smoker ❑ Light Smoker
If former smoker, date when you quit: _____
c. Do you drink alcohol? Yes ❑ No ❑ *If yes, how much?* _____ *how often?* _____
d. Do you take street or recreational drugs? Yes ❑ No ❑
e. Do you currently take medications? Yes ❑ No ❑ *If yes, what are the medications?* _____
f. Herbal or Dietary Supplements? Yes ❑ No ❑ *If yes, what are the supplements?* _____
g. Number of meals per day: _____ Number of "fast food" meals per week: _____
h. Number of Soft Drinks per day: _____ Do you use Artificial Sweeteners? _____
i. Exercise Regularly? Yes ❑ No ❑ How long? _____ How often? _____
j. How many ounces of water do you drink a day? _____
k. When was your last vision exam? _____
l. Have you ever had an injury/fracture/surgery to your spine? Yes ❑ No ❑ (If yes, explain _____
m. Do you have jaw pain? Yes ❑ No ❑ Do you grind your teeth? Yes ❑ No ❑
n. How many hours of uninterrupted sleep do you get per night? _____
o. Do you have a pacemaker? Yes ❑ No ❑
p. Are there any hobbies you do or would like to do that are affected by your condition? Yes ❑ No ❑
1) Hobby: _____ How much: Mild ❑ Moderate ❑ Significant ❑ Can't Do ❑
2) Hobby: _____ How much: Mild ❑ Moderate ❑ Significant ❑ Can't Do ❑
q. Are there any daily activities that you do or need to do that are affected by your condition? Yes ❑ No ❑
1) Activity: _____ How much: Mild ❑ Moderate ❑ Significant ❑ Can't Do ❑
2) Activity: _____ How much: Mild ❑ Moderate ❑ Significant ❑ Can't Do ❑

IV. PAST OR PRESENT MEDICAL CONDITIONS

Have you had or presently have any of the following conditions?

(PLEASE CHECK ALL THAT APPLY AND INDICATE WHETHER IT IS A CURRENT (C) OR PAST (P) ISSUE)

CONDITION	CHECK ONE	CONDITION	CHECK ONE
Musculoskeletal:		**Blood/Immune System:**	
☐ Neck Pain	☐ C ☐ P	☐ High cholesterol/triglycerides	☐ C ☐ P
☐ Mid Back Pain	☐ C ☐ P	☐ High glucose	☐ C ☐ P
☐ Low Back Pain	☐ C ☐ P	☐ Hypothyroidism / ☐ Hyperthyroidism	☐ C ☐ P
☐ Headaches ☐ Mild ☐ Mod. ☐ Severe ☐ Daily ☐ Weekly ☐ Monthly	☐ C ☐ P	☐ Diabetes	☐ C ☐ P
		☐ Allergies	☐ C ☐ P
☐ Numbness/Tingling ☐ Arm ☐ Hands ☐ Thighs ☐ Leg ☐ Foot	☐ C ☐ P	☐ Sinus Infections	☐ C ☐ P
		☐ Ear Infections	☐ C ☐ P
☐ Foot/Ankle Pain Right Left	☐ C ☐ P	**Digestive System:**	
☐ Hip Pain Right Left	☐ C ☐ P	☐ Acid Reflux/GERD	☐ C ☐ P
☐ Knee Pain Right Left	☐ C ☐ P	☐ Peptic ulcer *(gastric/duodenal)*	☐ C ☐ P
☐ Elbow Pain Right Left	☐ C ☐ P	☐ Constipation	☐ C ☐ P
☐ Carpal Tunnel Right Left	☐ C ☐ P	☐ Irritable Bowel Syndrome	☐ C ☐ P
☐ Plantar Fasciitis Right Left	☐ C ☐ P	☐ Nausea	☐ C ☐ P
☐ Arthritis	☐ C ☐ P	☐ Vomiting	☐ C ☐ P
☐ Rheumatoid Arthritis	☐ C ☐ P		
☐ Sciatica	☐ C ☐ P	**Vasculature:**	
☐ Herniated/Degenerated Disc Condition	☐ C ☐ P	☐ Varicose Veins	☐ C ☐ P
☐ Fibromyalgia	☐ C ☐ P	☐ Blood Clots	☐ C ☐ P
☐ Ear Aches Right Left	☐ C ☐ P	☐ Stroke/TIA	☐ C ☐ P
☐ TMJ Pain/Popping/Clicking Right Left	☐ C ☐ P	☐ Peripheral Artery Disease (PAD)	☐ C ☐ P
☐ Shoulder Pain Right Left	☐ C ☐ P	☐ Hardening of the Arteries	☐ C ☐ P
☐ Wrist Pain Right Left	☐ C ☐ P		
Heart:		**Lungs:**	
☐ High Blood Pressure	☐ C ☐ P	☐ Pneumonia	☐ C ☐ P
☐ Heart Attack	☐ C ☐ P	☐ Asthma	☐ C ☐ P
☐ Angina	☐ C ☐ P	☐ Bronchitis	☐ C ☐ P
☐ Congestive Heart Failure	☐ C ☐ P	☐ COPD	☐ C ☐ P
Nervous system:		☐ Emphysema	☐ C ☐ P
☐ Neuralgia/Diabetic Neuropathy	☐ C ☐ P		☐ C ☐ P
☐ Migraines	☐ C ☐ P	**Other Conditions:**	
☐ Seizures	☐ C ☐ P	☐ Chest Pressure/Tightness W/Exertion	☐ C ☐ P
☐ Pinched Nerves	☐ C ☐ P	☐ Chest Pressure/Tightness with Rest	☐ C ☐ P
☐ Depression	☐ C ☐ P	☐ Generalized Weakness	☐ C ☐ P
☐ Panic Attacks/Anxiety	☐ C ☐ P	☐ Cancer: Type:	☐ C ☐ P
☐ Balance Problems/Dizziness	☐ C ☐ P	☐ Night Sweats	☐ C ☐ P
Organ System:		☐ Trouble Breathing	☐ C ☐ P
☐ Kidney Stones	☐ C ☐ P	☐ Feeling Faint or Passing Out	☐ C ☐ P
☐ Gallstones	☐ C ☐ P	☐ Pain in Legs While Walking	☐ C ☐ P
☐ Hepatitis	☐ C ☐ P	☐ Recent Weight Loss: # Pounds Lost	☐ C ☐ P
☐ Bladder Infections	☐ C ☐ P	☐ Recent Weight Gain: # Pounds Gained	☐ C ☐ P
☐ Enlarged Prostate	☐ C ☐ P	☐ Swollen Feet or Ankles	☐ C ☐ P
	☐ C ☐ P	☐ Shoulder Dislocation Right Left	☐ C ☐ P

List any problems not mentioned above or other vital information: _____

_____

Name: _____

Massey Family Chiropractic

Dr. Jeff Massey

Informed Consent to Chiropractic Care

We encourage and support a **shared decision-making process** between us regarding your health needs. As part of that process you have the right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

- **Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

- **Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, 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; rather, recent studies indicate 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 process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. JEFF MASSEY TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS _____ DAY OF _____, 20_____

_____ _____

Patient Signature **Doctor Signature**

Parental Consent for Minor Patient:

Patient Name:_____ **Patient Age:** _____ **DOB:** _____

Printed name of person legally authorized to sign for patient:

Name: _____ **Relationship to patient:** _____

Signature: _____

5415 W. Friendly Ave., Suite B, Greensboro, NC 27410 Phone: 336-897-2026 Email: masseyfamilychiro@gmail.com
www.masseyfamilychiro.com

MASSEY FAMILY CHIROPRACTIC

Please initial each section below to indicate you have read and understand this information:

_____ **FINANCIAL RESPONSIBILITY**
I understand that payment for all services are due and payable at the time of service. I agree to pay all costs of collecting, securing, or attempting to collect or secure payment, including reasonable attorney fees or collection agency fees.

_____ **CONSENT FOR MEDICAL SERVICES**
I authorize Massey Family Chiropractic to render treatment to me/my dependent for chiropractic care/therapy as may be deemed necessary.

_____ **PRIVACY POLICY NOTICE**
A copy of Massey Family Chiropractic's Privacy Notice has been provided to me which outlines how my private health information may be used or disclosed and my rights related to the use and disclosure of this information. I have read and understand the information outlined in the notice.

_____ **CHILDREN**
I understand that children are not allowed in the treatment areas unless being seen by Dr. Massey. I further understand that children must be accompanied by an adult at all times. Exceptions may be made on a case by case basis for patients with infants.

_____ **CELL PHONES**
I understand that cell phone use is prohibited in the treatment areas. I also understand that audio and/or video recording is strictly prohibited within all areas of the Massey Family Chiropractic office. Such cell phone usage is a violation of HIPAA regulations.

_____ **MISSED APPOINTMENTS**
Our office requires a 24-hour notice for cancellations. Failure to do so may result in a $25 fee.

_____ **LATE ARRIVALS**
Late arrival to an appointment may result in you having to be worked into our existing schedule depending on the number of patients waiting to be seen when you arrive.

_____ **APPOINTMENT REMINDERS**
Text reminders will be sent the day before your scheduled appointment; however, you are still responsible for remembering your appointments if an unforeseen circumstance prevents us from sending a text reminder.

May we leave personal information on an answering machine or voicemail, if reached using your provided phone number? YES NO

_____	_____	_____
Date	Signature of Patient/Authorized Representative	Print Patient Name

HIPAA RELEASE FORM

*Patient Full Name*_____

*Patient Date of Birth*_____

The following are allowed information regarding the patient's condition and/or care at the office of Massey Family Chiropractic.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____

*Parent or Guardian Signature*_____ *Date* _____

*Parent or Guardian (please print)*_____

MASSEY FAMILY CHIROPRACTIC

Notice 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 it carefully.

Introduction

Massey Family Chiropractic is committed to giving you quality care and protecting your private health information (PHI). We are also committed to treating and using PHI 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 11/26/2016.

Understanding your Health Information

Each time you visit our office, a record of your visit is made. Typically, this record contains symptoms, examination and test results, diagnosis, treatment, and a plan for future care.

This information serves as a:

- Basis for planning your treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing care you received,
- Means by which you or a third party payer can verify that services billed were provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and 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 outcome we achieve.

Understanding what is in your record and how PHI is used helps you to ensure its accuracy, better understand who, what when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of Massey Family Chiropractic, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for by federal law (a reasonable fee may be charged to cover the cost of copying),
- Amend your health record as provided by federal law,
- Obtain an accounting of disclosures of your PHI as provided by federal law,
- Request communication of your PHI by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your PHI as provided for by federal law, and
- Revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

Our Responsibilities

- To maintain the privacy of your PHI
- To provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- To abide by the terms of this notice, and
- To 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 new provisions effective for all PHI we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied. Your responsibility is to notify us of address and insurance changes.

We will not use or disclose your PHI without your authorization, except as described in this notice. We will also discontinue to use or disclose your PHI after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of Disclosures for Treatment, Payment, and Health Operations:

Treatment: We may use your PHI within our office to provide health care services to you or we may disclose your PHI to another provider if it is necessary to refer you to them for services.

Payment: We may disclose your PHI to a third party such as an insurance carrier, an HMO, a PPO, or in order to obtain payment for services provided to you.

Personal Injury: We may disclose your PHI to your attorney in order to obtain payment for services provided to you.

Operations: We may use your PHI to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Business Associates: There are some services provided in our organization through contacts with associates. Examples include physician services in the emergency department, radiology, and certain lab tests, referrals to other physicians, and others who may provide work in our office. We may need to disclose your PHI to our business associates so they may perform the job we have asked of them. We have an agreement with these associates to protect your PHI as well.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose PHI 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.

Law Enforcement: We may disclose PHI for law enforcement purposes as required by law or in response to a valid subpoena.

Workers Compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other established programs by law.

Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with law relating to workers' compensation or other programs. Your provider is required by law to report communicable diseases and certain conditions to the Center for Disease Control in Atlanta, GA. Your PHI will be protected by our office and the CDC or health center.

FOR MORE INFORMATION

OR TO REPORT A PROBLEM

You may file a complaint with our practice's Privacy Officer, Tara Massey at 336-897-2026, or with the Department of Health and Human Services. There will be no retaliation for filing a complaint.

Office for Civil Rights

U.S. Dept. of Health & Human Services

200 Independence Ave. SW

Room 509 F, HHH Building

Washington, DC 20201

Para ver este aviso en espanol, vaya a:
www.HHS.gov