Welcome to Aurora Chiropractic Health Center

We thank you for choosing us for your chiropractic care. It is our goal to empower all our practice members to make great decisions regarding their health and their family's health.
In order to better serve you, please complete the following information.

Patient's name:_____ Date:_____/_____/_____

Street Address:_____ City:_____

State:_____ Zip:_____ Gender M F

Home # (___)_____-_____ Cell # (___)_____-_____ Work # (___)_____-_____

SS#:_____-_____-_____ D.O.B:_____/_____/_____ Nickname:_____

Marital Status:_____ Spouses name:_____

Emergency contact:_____ # (___)_____-_____

How did you hear about our office?_____

Previous chiropractic care? Y N last visit date?_____

Names and ages of children:_____

Employer:_____ Occupation:_____

Are you seeking care for a work related injury? Y N Auto Accident? Y N

Please check reasons for pursuing chiropractic care:

[ ] I'm continuing ongoing care from another chiropractor.
[ ] I'm interested in wellness and natural health care.
[ ] I'm concerned about my health and I'm looking for answers.
[ ] I have a specific condition or problem that concerns me.
Explain condition or symptom:_____
_____
[ ] I want to improve my immune function.
[ ] I have no idea why I'm here. Please take the time to explain to me what to do.

Insurance Company:_____ Policy #:_____

Subscriber name:_____ D.O.B:_____/_____/_____

In order for us to better understand your current level of health,
Please, check any of the following body signals which you have or have had previously:

[ ] Dizziness or fainting	[ ] Headaches	[ ] Postural Imbalance	[ ] Arthritis
[ ] Short leg / orthotics	[ ] Asthma	[ ] Ear Infections	[ ] Intestinal problems
[ ] Frequent colds	[ ] Sinus problems	[ ] High Blood pressure	[ ] Low blood pressure
[ ] Bladder problems	[ ] PMS	[ ] Kidney problems	[ ] Menopause symptoms

CHECK the following conditions that YOU have of have had,
CIRCLE conditions that are common to FAMILY MEMBERS:

[ ] AIDS / HIV	[ ] Alcoholism	[ ] Cancer	[ ] Epilepsy
[ ] Heart Disease	[ ] Lung Disease	[ ] Hypothyroidism	[ ] Hyperthyroidism
[ ] Multiple Sclerosis	[ ] Scoliosis	[ ] Heart Attack	[ ] Stroke
[ ] Diabetes	[ ] Ulcers		

Please list any other serious medical conditions you have had:_____

_____

Please list previous surgeries / treatments with dates:_____

_____

Please list any prescription or over the counter medications you currently take:_____

_____

_____

Do you have any known allergies?_____

List any past serious accidents with dates:_____

Do you smoke? Y N How much?_____ How Long?_____

Are you wearing [ ] Heel lifts [ ] Sole lifts [ ] Inner soles [ ] Arch supports

For Women:

Are you taking birth control? Y N Are you pregnant? Y N

I authorize the staff at to perform any necessary services needed during diagnosis and treatment.
I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature:_____ Date:_____/_____/_____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

The Stress Test

The following areas of stress can cause miss-aligned vertebra (subluxation).
Which of these stresses do you recognize?
Please CIRCLE when you experienced these stresses:
C (Child) T (Teenager) A (Adult)

Physical / Emotional / Chemical Stress:

Birth trauma	C			
Slips / Falls	C	T	A	
Car accidents	C	T	A	
Sports injuries	C	T	A	
Physical abuse	C	T	A	
Poor posture	C	T	A	
Sleeping on stomach	C	T	A	
Work injuries		T	A	
Sitting on wallet		T	A	
Extensive computer work		T	A	
Carrying heavy purse / book-bag /child		T	A	
Repetitive lifting / bending		T	A	
Driving many hours		T	A	
Continuous hours sitting / standing		T	A	
Children stress			A	
Career stress			A	
Relationship stress	C	T	A	
Concealed feelings	C	T	A	
Quick tempered	C	T	A	
Smoker / 2nd hand smoke	C	T	A	amount:_____
Poor diet / excessive sugar	C	T	A	
Caffeine	C	T	A	amount:_____
Artificial sweeteners	C	T	A	
Prescription drugs	C	T	A	
Over-the counter drugs (ex. Tylenol, motrin)	C	T	A	

Which do you feel are your primary stresses?

Patient authorization regarding chiropractic care being provided
in an "open adjusting" environment.

- It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting area at the same time. Patients may be within sight of one another and some ongoing routine details of care may be discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories or performing examinations. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters. In the event you or someone else would not agree with us we are providing this disclosure.

- It is our desire for our staff to use your name, address, e-mail address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and important office information such as office hour changes and cancellations.

- We would like to use your name, signature, photograph and/or radiograph on our "Patient of the Month" wall, our "Patient of the Week", and our Family Picture Wall. We would personally ask you previous to your inclusion with one of these activities. "Patient of the Week" is typically a surprise for you and may not be mentioned to you previously.

- It is our desire for our staff to use your name and/or signature on our sign in sheets in order to verify your office visit.

The use of this information is intended to make your experience with our office more efficient, more productive and to further enhance your access to quality Chiropractic care.

If you choose not to authorize this use of information, your decision will have no adverse affect on your care from Aurora Chiropractic Health Center or on your relationship with our staff.

Your signature indicates your authorization of the above mentioned activities.

Name (printed)	Signature	Date

If patient is a minor, or if you are being represented by another party

Personal Representative (printed)	Personal Representative (signature)	Date

Description of the authority to act on behalf of the patient

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization

HIPPA Notice of Privacy Practices

Aurora Chiropractic Health Center
32 Kearsarge Ave.
Contoocook, NH 03229
(603) 746-5353

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 this Practice may use and disclose your protected health information (PHI) to carry out treatment, payment of 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 or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, this Practice's staff and others outside of this Practice 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.

Care: In order to provide care to you, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your medical condition and needs and provide advice or treatment (e.g., your physician). For example, your physician may need to know how your condition is responding to the treatment provided by this Practice.

Payment: In order to receive payment for some or all of the health care provided by this Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your health insurance carrier with information about health care services that you received from the Practice so that the Practice can be properly reimbursed.

Health Care Operations: In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

AUTHORIZATION NOT REQUIRED

The Practice may use or disclose your PHI, without written authorization from you, in the following instances: Billing Service used for submitting insurance claims; Public Health Issues as required by law; Health Oversight Activities; Abuse, Neglect or Domestic Violence; Food and Drug Administration Requirements; Judicial and Administrative Proceeding; Law Enforcement Purposes; Coroner or Medical Examiner; Organ, Eye or Tissue Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required by Law.

Under the law, we must make disclosures 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 Practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of you rights with respect to your protected health information.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or 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 PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the 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 the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI 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 PHI. 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 PHI.

We reserve the right to change the terms of this notice and will inform you my mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 May 1, 2005.

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 office phone number.

Signature below is only acknowledgement that you have received and read this Notice of our Privacy Practices.

Print Name: _____ Date: _____

Signature: _____