APPLICATION FOR CARE AT ITHACA FAMILY CHIROPRACTIC

PATIENT DEMOGRAPHICS

DATE:_____

Name: _____ Birth Date: _____-_____-_____ Age: ____ ○Male ○Female ○Non-Binary

Home Phone: _____-_____-_____ Mobile Phone:_____-_____-_____ Preferred Pronoun:_____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Marital Status: ✖Single ✖Married ✖Legally Separated ✖Divorced ✖Widowed

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Date of Birth:_____

Spouse's Employer _____Number of children and ages:_____

Name & Number of Emergency Contact: _____ _____Relationship: _____

Hobbies and Interests: _____Whom may we thank for referring you?_____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

Primary or chief complaint is: 0 –1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 –1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 –1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 –1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ○ AM ○ PM ○ mid-day ○ late PM

How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen?_____

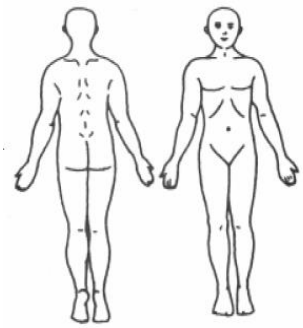
Condition(s) ever been treated by anyone in the past? ○No ○Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ✖ **N/A**

Name of Primary Care Provider: _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R =Radiating **B =B**urning **D =D**ull **A =A**che **N =N**umbness **S =S**harp/**S**tabbing **T =T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Is your problem the result of ANY type of car or work accident? ○Yes ○No

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Are you here for (Circle one):

1. Regular maintenance of the spine and nervous system.
2. Relief care and regular maintenance of the spine and nervous system.
3. Relief care only to get out of pain.

SOCIAL HISTORY

1. Smoking: ×cigars ×pipe ×cigarettes ×smokeless tobacco How often? ×Daily ×Weekends ×Occasionally ×Never
2. Alcoholic Beverage: consumption occurs ×Daily ×Weekends ×Occasionally ×Never
3. Recreational Drug use: ×Daily ×Weekends ×Occasionally ×Never

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? × No × Yes **If yes,** how many times? _____ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ○No ○Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____** Were the results: ○Favorable ○Unfavorable please explain.
_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*****, C** for ***Currently*** have or **N** for ***Never*** have had**:**
___Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability ___Cancer
___Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular ___ Blood Clots

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carrying	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sit to Stand	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Lifting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Getting Dressed	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Household Chores	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

Driving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

Please mark **P** for in the **Past, C** for **Currently** have, or **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)
___ COVID-19	___ COVID-19 Vaccine	___ Vascular Problems	__ Other:_____	

List Prescription & Nonprescription drugs you take: _____

_____

FAMILY HISTORY

Many conditions run in the family. Please ✔any conditions in your family.

Condition	Children	Spouse	Siblings	Father	Mother	Grandparents
Shoulder / Arm Pain						
Arthritis RA/PA/OA						
Asthma						
ADD/ADHD/OCD						
Allergies / Sinus Issues						
Back Pain Upper / Lower						
Bed Wetting / Bladder Issues						
Depression / Nervousness / Anxiety						
Digestive Problems						
Disc Problems						
Ear Infections						
Foot/Heel Pain						
Fibromyalgia/Pain Syndrome						
Headaches/Migraines						
Heartburn/Reflux						
High/Low Blood Pressure						
Hip / Leg Pain						
Neck Pain						
Sciatica / Pinched Nerve						
Scoliosis						
Hypo/Hyper Thyroidism						

TMJ/Jaw Pain						
Trouble Sleeping						
Other:						

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please carefully read instructions: Please indicate the number which best describes the question being asked for each area of complaint.

○ **Primary concern:** _____

△ **Secondary concern:** _____

□ **Third concern:** _____

☆ **Fourth concern:** _____

Example:

○ ***Primary concern:*** *Headaches*

△ ***Secondary concern:*** *Neck*

□ ***Third concern:*** *Low Back*

☆ ***Fourth concern:*** *Shoulder*

No Pain _____ ***Worst Possible Pain***

0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

INFORMED CONSENT REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at ITHACA FAMILY CHIROPRACTIC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ *Witness Initials*
Patient or Authorized Person's Signature Date

INSURANCE

Do you have Insurance: ✖Yes ✖No Gender at Birth ○ Male ○ Female

I hereby authorize payment to be made directly to ITHACA FAMILY CHIROPRACTIC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to ITHACA FAMILY CHIROPRACTIC for any and all services I receive at this office.

Name of Insured:_____

Relationship to Patient: _____ Birthday of Insured:_____

_____ ____/____/____ *Witness Initials*
Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

EVERYONE By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ *Witness Initials*
Patient or Authorized Person's Signature Date

FEMALES ONLY *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

○ The first day of my last menstrual cycle was on ____-____-____ (Date)

○ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

MEDICAL INFORMATION RELEASE FORM (HIPPA Release Form)

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse Name:_____

[ ] Child(ren) Name(s):_____
[ ] Other Name: _____

[ ] Check here if you **DO NOT** want information released to your primary care provider.
[ ] Information is **NOT** to be released to anyone.
This ***Release of Information*** will remain in effect until terminated by me in writing.

_____ ____/____/____ *Witness Initials*
Patient or Authorized Person's Signature Date

ITHACA FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or the general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different from residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Brian Bartholomew at (607) 257-9355. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of Ithaca Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this “Notice” is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient’s Name	DOB
Patient’s Signature	Date