Cousineau Chiropractic
14550 King Rd
Riverview, MI 48193

Cousineau Chiropractic Life Center, P.C.

734-479-1880

Welcome to our office!
It is an honor to be of service to you.
Please complete the following confidential patient health record.

Pediatric Patient Information

Date: ____________________ Patient ID Number ____________________

Patient Name: ________________________________ Date of Birth:___/___/___ ☐ Male ☐ Female

Address: ____________________________ City:____________________ State:_____ Zip:_______

Name(s) of ☐ Parent(s), ☐ Guardian(s), or ☐Other: ________________________________

Address (if different from patient):________________________________

Home phone:____________________________ Cell Phone:____________________

Has patient ever been to a chiropractor? ☐ Yes ☐ No

Ifanyeberwhensuasdrhe ☐ lastemisit? Cousineau, D.C. ☐ Nicole R. Cousineau, D.C. ☐ Kristin J. Cousineau, D.C
☐ Joseph A. Shusteric, D.C. ☐ ____________________

Referral: ☐ Mail ☐ Newspaper/TV ☐ Phone Book ☐ Speaking Engagement
☐ Expo ☐ Former Patient ☐ Walk In ☐ Patient/Friend

Whom may we thank for referring you to us?____________________________

Insurance Information

Name of Primary Insurance Carrier ________________________________

Insured's Name & Address: ________________________________

Relationship to patient: ☐ Parent ☐ Guardian

Insured's Birthdate: ________________________________

Insured's Employer________________________________ Retired? ☐ Yes ☐ No

Insured's Social Security Number________________________________

DO YOU HAVE A HEALTH SAVINGS ACCOUNT? Yes____ No____

☐ **Flex Spend Account** ☐ **Health Savings Account (HSA)** ☐ **HRA** ☐ **EHIM** ☐ **MEBS (Messa)**

Name of Secondary Insurance Carrier________________________________

Insured's Name & Address: ________________________________

Relationship to Patient: ☐ Parent ☐ Guardian

Insured's Birthdate: ________________________________

Insured's Employer Retired? ☐ Yes ☐ No

I hereby authorize & consent the Cousineau Chiropractic Life Center to administer chiropractic evaluation, treatment and/or x-rays as deemed necessary to my son/daughter.

Parent/Guardian Signature:________________________________

Date:________________________________

Witness:________________________________

Name_____

History of Birth

Date _____

Patient Number_____

Hospital/Birthing Center: ☐ Home ☐ Medical ☐ Midwife Duration of Gestation: _____ weeks

Was the birth assisted? ☐ Yes ☐ No If yes, how? ☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Induced Labor

Were medications given to the mother at birth? ☐ Yes ☐ No If yes, what? _____

Was the delivery normal? ☐ Yes ☐ No If no, what complications were there at birth? _____

Was an epidural administered? ☐ Yes ☐ No

Growth and Development

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes, etc.) _____

The father's side?_____

Do the child's siblings have any health problems? ☐ Yes ☐ No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke ☐ Yes ☐ No 2. Drink alcohol? ☐ Yes ☐ No

3. Take supplements/vitamins? ☐ Yes ☐ No 4. Take drugs? ☐ Yes ☐ No If yes, what? _____

5. Become Ill? If so, how? _____

6. Receive invasive procedures (i.e. amniocentesis, CVS, ultrasounds)? ☐ Yes ☐ No

Was your child breast fed? ☐ Yes ☐ No If yes, for how long?_____ weeks months years

At what age was: 1a. Formula introduced?_____ b. Brand?_____

2. Cow's milk?_____ yrs 3. Solid Foods?_____yrs

Did your child receive vaccinations? ☐ Yes ☐ No If yes, which ones?_____

Did your child react to them? ☐ Yes ☐ No

Has your child had antibiotics? ☐ Yes ☐ No

If yes, how many courses has the child had so far & why? _____

Any pets at home? ☐ Yes ☐ No Any smokers at home? ☐ Yes ☐ No If yes, How much?_____

Psychological Stressors

Any difficulties with lactation? ☐ Yes ☐ No Any problems bonding? ☐ Yes ☐ No

Does your child seem normal to you? ☐ Yes ☐ No

Does the child have any behavior problems? ☐ Yes ☐ No If yes, what? _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? ☐ Yes ☐ No If yes, specify:_____

Traumatic Stressors

Any evidence of trauma during birth? ☐ Stuck in birth canal ☐ Cord around neck ☐ Fast and/or excessively long birth ☐ Odd shaped head ☐ Bruises ☐ Respiratory Depression ☐ Other_____

Any falls/accidents during pregnancy? ☐ Yes ☐ No Has the child had any major falls since birth? ☐ Yes ☐ No

If yes, did the child need stitches or cause a fracture? Please describe:_____

Any hospitalizations? ☐ Yes ☐ No Please explain:_____

Does your child play sports? ☐ Yes ☐ No Number of hours per week?_____ Age child began _____yrs

Weight of school backpack? _____ lbs

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Pediatric Patient Introduction

Date _____ Patient # _____

Name _____ Age ___ Current Height (length):_____ Current weight: _____

Current Health Complaints (Symptoms)_____

What Day Did Symptoms Start: (Date) _____

Duration of problem or episode: (circle one) Minutes - Hours - Days - Months - Years

Onset was: (circle one) Sudden - Gradual - Associated with event _____

Pattern of Problem: (circle one) Constant - Intermittent - Occasional - Cyclical

Aggravating Factors:_____ Relieving Factors: _____

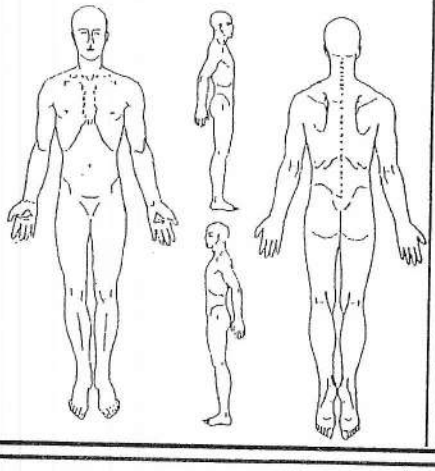
How does the problem affect your child's body function and activities of daily living _____

_____

Prior occurence or episodes: _____

Please Mark The Problem Areas With The Following Letter:

A - Ache
P - Pain
N - Numbness
T - Tingling
B - Burning
S - Stabbing
R - Radiating



List Surgeries _____

_____

_____

Medications _____

_____

_____

Allergies _____

_____

_____

Other _____

_____

_____

Has this child ever suffered from:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Colds/Flu
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Walking Trouble
- ☐ Digestive Disorders
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Hypertension
- ☐ Anemia
- ☐ Behavioral Problems
- ☐ ADD/ADHD
- ☐ Ruptures/Hernia
- ☐ Muscle Pain
- ☐ Growing Pains
- ☐ Bed Wetting
- ☐ Broken Bones
- ☐ Colic
- ☐ Other _____

Has this child ever suffered the following spinal traumas?

- ☐ Fall in baby walker
- ☐ Fall from crib
- ☐ Fall from highchair
- ☐ Fall from changing table
- ☐ Fall from bed or couch
- ☐ Fall off swing
- ☐ Fall off slide
- ☐ Fall off monkey bars
- ☐ Fall off skateboard or skates
- ☐ Fall off bicycle
- ☐ Fall down stairs
- ☐ Other _____

Female Patients:

Are you pregnant? _____
When are you due? _____
Are you nursing? _____

PAIN RATING, MEDICATION, AND SURGERIES

Patient Name_____ Date_____ Patient #_____

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List all Drug Allergies_____

☐ No known drug allergies

Circle and list all medications that apply

☐ No prescription medication taken

Anti-inflammatories_____
Sleeping aides_____
Narcotic pain relievers_____
Acetaminophen_____
Anti-anxiety medication_____
Anti-depressants_____
Muscle relaxants_____
Medicated patches_____
Anticonvulsants (ex. Neurontin)_____

List all other medications/supplements below

☐ No supplements taken

Indicate the types of surgery ☐ No surgeries performed

Circle all surgeries below and date performed

Lumbar fusion_____
Lumbar laminectomy/decompression_____
Posterior cervical surgery_____
Anterior cervical surgery_____
Left hip surgery_____
Right hip surgery_____
Left shoulder surgery_____
Right shoulder surgery_____

List additional surgeries below and dates

SOCIAL HISTORY

Are you working? ☐Yes ☐No

What best describes your type of work?

☐ Retired ☐ Not employed

Race: _____

Ethnicity: (i.e. Hispanic, Latino, Mexican, Italian, English, Jewish, French, Japanese, Chinese, Arabic, Latino) Other _____

Preferred Language: _____

☐ Sedentary duty - Occasional lifting/carrying small items (10 lbs. max.). Walking and standing required occasionally

☐ Light duty - Frequent lifting (20 lbs. max) and carrying objects (10 lbs. max.). Significant walking/standing with sitting, pushing, pulling.

☐ Medium duty - Lifting (50 lbs. max) with frequent lifting/carrying of objects (25 lbs. max).

☐ Heavy duty - Lifting (100 lbs. max) with frequent lifting/carrying of objects (50 lbs. max).

☐ Very heavy duty- Lifting objects (heavier than 100 lbs.) with frequent lifting/carrying of objects (heavier than 50 lbs.)

Do you drink alcohol? ☐ Never ☐ Occasionally ☐Socially ☐ Frequently (more than 3 days per week)

Do you smoke? ☐ Never ☐ Occasionally ☐ Frequently

Do you chew tobacco? ☐ Never ☐ Occasionally ☐ Frequently

Have you had substance abuse treatment? ☐ Yes ☐ No

Have you ever used illegal drugs? (Marijuana, crack, cocaine, etc.) ☐ Yes ☐ No

What is your educational level? (Select the highest level you have achieved)

☐ Not completed high school ☐ High school graduate ☐ GED diploma or equivalent
☐ Completed trade school ☐ An associates degree ☐ Completed business school
☐ A bachelor's degree ☐ A masters degree
☐ Completed law school ☐ A PH.D. ☐ Completed medical school

Height_____
Weight_____
Blood Pressure ____/____

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AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Cousineau Chiropractic Life Center to disclose to my Insurance Company or lawyer and all necessary information, which has been acquired by examination or other means of my physical or mental condition, and I release Cousineau Chiropractic Life Center of any consequences thereof.

X-RAYS

Under the laws of the Srare of Michigan, x-rays are the property of this office. The amount paid by you or the Insurance Company are for interpretation. However, if needed, a copy can be made available.

ASSIGNMENT OF PAYMENT

My attorney and or insurance Company are hereby requested and authorized to pay direct to Cousineau Chiropractic Life Center any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Cousineau Chiropractic Life Center the difference between the total amount of the charges and the amount paid by the attorney and or the Insurance Company. It is further understood that I, the undersigned, agree to pay Cousineau Chiropractic Life Center the full amount of the charges, should my condition be such that is not covered by my policy or if for any reason the Insurance Company refuses to pay the full amount of my claim.

Signature of Applicant (or Agent) _____

Relation to Patient if signed by Agent _____

Date _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

You can reach the Privacy Official at: Cousineau Chiropractic Life Center P.C. 14550 King Road ,Riverview, Mi. 48192: 734-479-1880 business days

. Section 8: Notice of Privacy Practices Acknowledgement Initial Uses Authorization Form Cousineau Chiropractic Life Center P.C. Effective: 4-15-2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Cousineau Chiropractic Life Center P.C.. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Jennifer Totten

Cousineau Chiropractic Life Center P.C. also uses protected health information for the following reasons: (you may opt out of this authorization). Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial to give us authorization)

If you have any questions regarding this notice or our health information privacy policies, please contact: Jennifer Totten You can reach the Privacy Official at: Cousineau Chiropractic Life Center P.C., 14550 King Road, Riverview, Mi. 48192, 734-479-1880 Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: _____(you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

==========

Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

□ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices

□ Other:

_____

Staff Signature: _____date: _____

We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

Your rights regarding your health information:

1. Right to Request Restrictions: Right to Request Restrictions: You have the right to request disclosure restrictions of PHI to a health plan with respect to healthcare for which you have paid out of pocket in full where not elsewhere restricted by law.
2. Cousineau Chiropractic Life Center P.C. is required by law to provide to you a notification of all demonstrated breaches of your PHI.
3. Communications. You can request that Cousineau Chiropractic Life Center P.C. communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that Cousineau Chiropractic Life Center P.C. contact you at home, rather than work. Cousineau Chiropractic Life Center P.C. will accommodate reasonable requests.
4. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that Cousineau Chiropractic Life Center P.C. restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. Cousineau Chiropractic Life Center P.C. is not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
5. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Privacy Official: Jennifer Totten.
6. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Official: Jennifer Totten. You must provide us with a reason that supports your request for the amendment
7. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our Privacy Official: Jennifer Totten.
8. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Regional Office for Civil Rights, US Department of Health and Human Services. Regional Office information may be found online athttp://www.hhs.gov/ocr/office/about/rgn- or ask the Privacy Official for the information. To file a complaint with our practice, contact our Privacy Official: Jennifer Totten. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
9. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

In accordance with the standards of implementation specifications of 45 C.F.R. § 164.524, Provider may grant an individual access to inspect and obtain a copy of protected health information about the individual in a designated record set.

Cousineau Chiropractic Life Center P.C. s policy:

1. The designated record set that is subject to access by an individual is as follows:
    1. Medical Records
    2. Billing Records
    3. List of all those requesting copies of designated record set
2. The titles of the persons or offices responsible for receiving and processing requests for access by individuals are as follows:
   Privacy Official: Jennifer Totten

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Marketing; internal referral board, testimonials, pictures on bulletin board, sending newsletters or information unrelated to healthcare and other marketing materials.

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AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Cousineau Chiropractic Life Center to disclose to my Insurance Company or lawyer and all necessary information, which has been acquired by examination or other means of my physical or mental condition, and I release Cousineau Chiropractic Life Center of any consequences thereof.

X-RAYS

Under the laws of the State of Michigan, x-rays are the property of this office. The amount paid by you or the Insurance Company are for interpretation. However, if needed, a copy can be made available.

ASSIGNMENT OF PAYMENT

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Signature of Applicant (or Agent) _____

Relation to Patient if signed by Agent _____

Date _____