MINDFUL FAMILY CHIROPRACTIC

DETAILED INFO

DATE:_____

NAME:_____ NICKNAME:_____
ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____-_____

If you are a seasonal resident please check here ( )
Local Address:
_____ City:_____ Zip:_____

EMAIL ADDRESS:_____

PHONE # (H): _____-_____ (W):_____-_____ (CELL):_____-_____

SS NO.:_____-_____-_____ AGE:_____ DOB:_____/_____/_____ SEX:_____

OCCUPATION:_____ ( ) FT ( ) PT Employer:_____ ( ) Unemployed ( ) Retired ( ) Homemaker

STUDENT? ( ) FT ( ) PT Name of School:_____

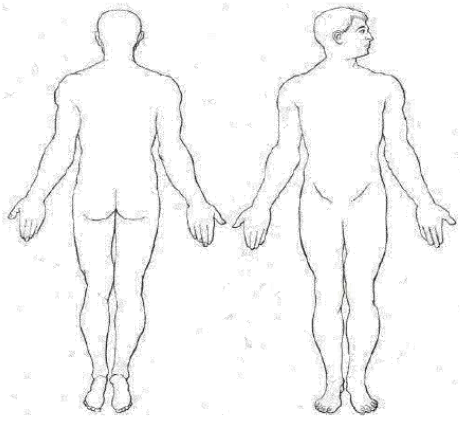
EMERGENCY CONTACT INFORMATION:

Name:_____ Phone:_____ Relation to Patient:_____

How did you find our office?
( ) INTERNET ( ) WALK BY ( ) OTHER _____ ( ) REFERRAL FROM FAMILY/FRIEND

WHO can we thank for referring you to the office?_____

PLEASE MARK THE EXACT LOCATION(S) OF YOUR PAIN(S):



LIST MAJOR COMPLAINT(S) IN ORDER OF SEVERITY:

1)_____

2)_____

3)_____

4)_____

Have you ever been to a Chiropractor? ( ) yes ( ) no
Name (s) & location:_____

Do you have a pace maker: YES_____ NO_____

Is there a possibility of pregnancy at this time? YES_____ How many weeks?_____ "Due date:_____
pregnancy:_____ # children:_____ Healthcare Practitoner:_____

CHECK SYMTOMS YOU HAVE NOTICIED PT ID:_____

___ Headache	___ Irritability	___ Shortness of breath	___ Face Flushed
___ Neck Pain	___ Chest Pain	___ Fatigue	___ Diarrhea
___ Sleep Problems	___ Pins & Needles in arms	___ Depression	___ Fainting
___ Back Pain	___ Pins & Needles in legs	___ Light bothers eyes	___ Loss of smell
___ Nervousness	___ Numbness in fingers	___ Loss of memory	___ Loss of taste
___ Tension	___ Numbness in toes	___ Ringing in ear(s)	___ Balance
___ Feet Cold	___ Hands Cold	___ Upset stomach	___ Constipated
___ Cold Sweats	___ Fever	___ Head seems heavy	___ Balance changes

How did CURRENT condition develop?_____

When were you first aware of this problem? _____

Have you ever had this or a similar problem before? if yes, when, where, what were the results:

_____

Has your condition been getting better, worse, or staying the same?:_____

Is this keeping you from any daily activities*: ( )dressing ( )driving ( )eating ( )lifting ( )pulling ( )pushing ( )running ( )walking ( )exercising ( )typing ( )working ( )gardening ( )cooking ( )cleaning ( )sleeping ( )up/down stairs ( )bathing ( )using restroom ( )other* _____

Have you lost any days from work due to this condition? If yes, dates:_____

Occupation ergonomic (on your feet, drive, at a computer, etc)**:**_____

LIFESTYLE

Exercise/Recreation Activities: *( )run ( )walk ( )lift weights ( )stretches ( )golf ( )tennis ( )swim ( )other:* _____

Rest & Sleep (#hours/position): ____ Hrs; Position: *( )right side ( )left side ( )stomach ( )back*
Quality: ( )poor ( )restless ( )good ( )sound ( )insomnia

Diet: *( )controlled ( )out of control ( )vegetarian ( )vegan ( )no red meat ( )gluten free ( )diabetic*
Allergies/restrictions_____ *( )personal ( )medical necessity*

Alcohol: *( )none ( )social ( )light ( )moderate ( )heavy;* **Caffeine:** *( )none ( )1 cup/day ( )2+ cups/day ( )5+ cups/day*
Cigarettes: *( )none ( )light ( )moderate ( )heavy;* **IF NONE:** *( ) Never smoked ( ) Quit:* _____ *ago*
Medications/supplements/vitamins/recreational drugs:_____
(provide a separate list if need be)

Any auto accidents: *( )yes ( )no* **Date:**_____ **Any Falls:** *( )yes ( )no* **Date:**_____
Explain:_____

Have you had ANY surgeries: ( ) None _____

ANY hospitalizations? ( ) None _____

PERSONAL HISTORY ( ) None
Do YOU have/had: high or low blood pressure? _____ Any heart problems ___ Aneurysms_____
Phlebitis____ HIV____ Diabetes _____ Cancer _____ Other _____
If YES to any, explain:_____

FAMILY HISTORY ( ) None
Has anyone in your immediate family had high or low blood pressure? ____ heart problems ____ Aneurysms_____
Phlebitis____ HIV____ Diabetes _____ Cancer _____ Other _____

Explain: (who/what) _____

Fees are payable at time of examination and treatment are received unless other arrangements are made in advance. Records remain the property of this clinic.

SIGNATURE:_____ **DATE:**_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and herby grant permission for my child to receive chiropractic care.

Dr. Signature _____

PID _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:__________________________ Signature:_________________________________ Date:____________________

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine a appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

PID __________________

The use of these machines is for symptomatic relief of chronic, intractable pain, muscle spasms and joint contractures.

PLEASE READ THE FOLLOWING INFORMATION REGARDING CONTRAINDICATION AND NOTIFY THE DOCTOR IF ANY OF THESE CONDITIONS APPLY TO YOU OR **IF YOU ARE UNSURE, PLEASE ASK!!**

Electrical Stimulation Contraindications:

- Demand type cardiac pacemakers
- Use over cancerous lesions

Ultrasound Contraindications:

- An area of the body where a malignancy is known to be present
- An acute infection or sepsis
- Pregnancy
- Deep Vein thrombosis (DVT)
- Arterial Disease
- An anesthetized area or condition that causes impairment of sensation, such as
- chemotherapy
- Cardiac pacemaker
- A healing fracture
- Ischemic tissue in individuals with vascular disease where the blood supply would be compromised
- Any metal in the body

I, _____, I have read the above statement and to the best of my knowledge do not have any of the above listed contraindications to the use of the electric stimulations and ultrasound equipment, or have indicated which I do have and am aware I cannot receive that particular therapy.

_____ _____

Signature Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address:_____@_____ **PID** _____

Preferred method of communication for patient reminders (circle one): Email / Phone / Mail

DOB: ___/___/_____ **Gender (circle one):** Male / Female **Preferred Language**:_____

Smoking Status (circle one): Everyday Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (circle one): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I decline to answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Are you currently taking any medications? (please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (ie: 5mg once a day)

Do you have any medication allergies ?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit. *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:_____ Date:_____

PT ID _____

MINDFUL FAMILY CHIROPRACTIC

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ Date of Birth:_____

Please check one of the following

_____ I give permission to the employees of Mindful Family Chiropractic to disclose my Protected Health Information to me and the following friends or family

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other family or friends.

I understand that I may revoke or change this consent at any time by filling out another consent form to replace this one.

_____ _____

Signature of Patient Date

☐ Please check this box if you would like Mindful Family Chiropractic to provide your OBGYN/Midwife or PCP an overview of your initial visit. By selecting this option, you give permission for the doctors and staff to communicate your treatment plan and condition to the provider listed below. This ensures all parties are communicating effectively for your care.

Provider Name :_____ Office Location:_____ Phone:_____