FUNCTIONAL LIVING
CHIROPRACTIC

2132 Five Mile Line Rd, Ste E
Penfield NY 14526
585-469-1571

PATIENT INFORMATION

Name:	Martial Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Other
Preferred Name:	Home Phone #:
DOB:	Cell Phone #:
Mailing Address:	Work Phone #:
	Email:
	How did you hear about us?

PRIMARY CARE PHYSICIAN

Physician's Name:	Clinic/Facility Name:
Mailing Address:	Phone Number:
	Fax Number:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Secondary Insurance:	Subscriber's Name:
Subscriber's DOB:	Subscriber's DOB:
Policy/ID #:	Policy/ID #:
Relationship to Subscriber: ❑Self ❑Spouse ❑Dependent ❑Other	Relationship to Subscriber: ❑Self ❑Spouse ❑Dependent ❑Other
Subscriber's Employer	Subscriber's Employer:
Employer's Address	Employer's Address:
Employer's Phone #:	Employer's Phone #:
Current Occupation: _____	❑ Full Time ❑ Part-time

EMERGENCY CONTACT

Name:	Phone #:
Relationship to Patient:	Alternative Phone #:

ASSIGNMENT OF BENEFITS & HIPPA RELEASE

By signing below, I certify that I, and/or my dependent(s) have insurance coverage with the above-names company(ies) and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use by health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the signed date below.

_____ _____

Patient/Guardian Date

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PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME:_____ DATE:_____

1. What is the reason for your visit today? _____

a. Approximately when did it start? _____

b. What brought on this current episode? _____

c. Is this episode a worsening of a prior injury? _____

2. Location (where does it hurt?): _____

3. Nature of symptoms (check all that apply): ❑ Numbness ❑ Tingling ❑ Stiffness ❑ Dull ❑ Aching ❑ Cramps ❑ Nagging ❑ Sharp ❑ Burning ❑ Shooting ❑ Throbbing ❑ Stabbing ❑ Other _____

4. What is the intensity of your symptoms?

	None				Mild			Moderate			Severe
Currently:	0	1	2	3	4	5	6	7	8	9	10
At its worse:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10

5. How often do you experience symptoms?

❑ **Constantly** (76-100% of the time)
❑ **Frequently** (51-75% of the time)
❑ **Occasionally** (26-50% of the time)
❑ **Intermittently** (0-25% of the time)

6. What makes your symptoms worse? _____

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7. Other/Prior Treatment (s): What have you done to relieve your symptoms?

❑ Chiropractic ❑ Acupuncture ❑ Prescription meds: _____
❑ Physical Therapy ❑ Massage ❑ Over-the-counter meds: _____
❑ Surgery: _____ ❑ Homeopathic Remedies: _____

8. Activities of Daily Living: How does this condition interfere with your life and ability to function?

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Standing	❑	❑	❑	❑	Using a Computer	❑	❑	❑	❑
Rising out of a Chair	❑	❑	❑	❑	Driving/Riding in a Car	❑	❑	❑	❑
Standing	❑	❑	❑	❑	Looking Over Shoulder	❑	❑	❑	❑
Walking	❑	❑	❑	❑	Exercising	❑	❑	❑	❑
Lying Down	❑	❑	❑	❑	Showering/Bathing	❑	❑	❑	❑
Bending Over	❑	❑	❑	❑	Dressing Myself	❑	❑	❑	❑
Climbing Stairs	❑	❑	❑	❑	Social Life	❑	❑	❑	❑
Lifting Objects	❑	❑	❑	❑	Rolling Over in Bed	❑	❑	❑	❑
Reaching Overhead	❑	❑	❑	❑	Staying Asleep	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	Concentrating	❑	❑	❑	❑
Yard Work	❑	❑	❑	❑					

9.Additional Information: Height: _____ Weight: _____ Smoking Status: ❑ Smoker ❑ Non-Smoker

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PATIENT HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

Instructions: *If you are currently troubled by a particular condition, or if you have ever had a listed condition in the past, please mark the appropriate column below. The information you provide concerning past and present conditions assist your doctor in more thoroughly understanding your state of health. This questionnaire is completely confidential and will not be released without your specific consent.*

Past	Present	
❑	❑	Neck Pain
❑	❑	Shoulder Pain
❑	❑	Pain in Upper Arm or Elbow
❑	❑	Hand Pain
❑	❑	Wrist Pain
❑	❑	Upper Back Pain
❑	❑	Lower Back Pain
❑	❑	Pain in Upper Leg or Hip
❑	❑	Pain in Lower Leg or Knee
❑	❑	Pain in Ankle or Foot
❑	❑	Jaw Pain
❑	❑	Joint ❑ Swelling / ❑ Stiffness
❑	❑	Fainting
❑	❑	Visual Disturbances
❑	❑	Convulsions
❑	❑	Dizziness
❑	❑	Headache/Migraine
❑	❑	Muscular Incoordination
❑	❑	Tinnitus (Ear Noises)
❑	❑	Rapid Heart Beat
❑	❑	Chest Pain
❑	❑	Loss of Appetite
❑	❑	Irritable Colon (Bowel)
❑	❑	Excessive Thirst
❑	❑	Chronic Cough
❑	❑	Chronic Sinusitis
❑	❑	General Fatigue
❑	❑	Irregular Menstrual Cycle
❑	❑	Profuse Menstrual Cycle
❑	❑	Breast Soreness/Lumps
❑	❑	Endometriosis
❑	❑	PMS
❑	❑	Loss of Bladder Control
❑	❑	Painful Urination
❑	❑	Frequent Urination
❑	❑	Abdominal Pain
❑	❑	Constipation/Irregular Bowel Habits
❑	❑	Difficulty Swallowing
❑	❑	Heartburn/Indigestion
❑	❑	Dermatitis/Eczema/Rash
❑	❑	Depression
❑	❑	Other: _____

Past	Present	
❑	❑	Aortic Aneurysm
❑	❑	High Blood Pressure
❑	❑	Angina
❑	❑	Heart Attack When: _____
❑	❑	Stroke When: _____
❑	❑	Asthma
❑	❑	Cancer What kind: _____
❑	❑	Tumor
❑	❑	Prostate Problems
❑	❑	Blood Disorder
❑	❑	Emphysema
❑	❑	Arthritis
❑	❑	Rheumatoid Arthritis
❑	❑	Diabetes ❑ Type I ❑ Type II
❑	❑	Epilepsy
❑	❑	Ulcer
❑	❑	Liver Problems
❑	❑	Gallbladder Problems
❑	❑	Kidney Stones
❑	❑	Hepatitis
❑	❑	Bladder Infection
❑	❑	Kidney Disorders
❑	❑	Kidney Stones
❑	❑	Colitis
❑	❑	Abnormal Weight ❑ Gain ❑ Loss
❑	❑	HIV/AIDS
❑	❑	Anorexia
❑	❑	Systemic Lupus
YES	NO	
❑	❑	Tobacco ❑ Past ❑ Presnt
❑	❑	Alcohol, If yes frequency: _____
❑	❑	Drug/Alcohol Dependence
❑	❑	Coffee/Teat/Caffeinated Soft Drinks Servings per day: _____
❑	❑	Surgeries: _____ _____
❑	❑	Accidents/Injuries: _____ _____
❑	❑	Medications: _____ _____
❑	❑	Allergies: _____ _____

Immediate Family Medical History:

❑ Cancer	❑ Chronic Back Problems
❑ Heart Problems	❑ Chronic Headaches
❑ Lung Problems	❑ High Blood Pressure
❑ Diabetes	❑ Rheumatoid Arthritis
❑ Epilepsy	❑ Lupus
❑ Other: _____	

YES	NO	For Women
❑	❑	Are you on any form of Birth Control?
❑	❑	Are you nursing?
❑	❑	Are you or could you be pregnant?
		If yes, how far along? _____
		If no, last period? _____

INFORMED CONSENT TO CHIROPRACTIC CARE

THIS NOTICE DESCRIBES WHAT A PATIENT MAY EXPECT AS IT PERTAINS TO TREATMENT IN THIS OFFICE AND INDICATES THE PATIENT'S CONSENT TO SUBMIT TO A COURSE OF CARE. PLEASE REVIEW IT CAREFULLY

☐ **CHIROPRACTIC CARE AND TREATMENT**. I have and have had an opportunity to discuss with the chiropractic doctor, or other office or clinical personnel named below, the nature and objective of chiropractic care, the physical examination and other diagnostic tests and procedures used by chiropractors including any necessary orthopedic, neurological, laboratory tests, imaging studies (X-rays, CT scans, MRIs, etc) and other procedures; chiropractic care and treatment protocols, including chiropractic adjustments, manipulation, mobilization and other therapies utilized by this office/practice in the care of my condition. Taken together, these procedures and protocols will be referred to as the office/practice's "chiropractic examination and treatment methods." Furthermore, it also has been communicated to me and I understand that every patient reacts differently to care, and that treatment results and outcomes cannot be guaranteed.

☐ It also has been explained to me that if any tests were performed outside of this office/practice (e.g., laboratory or other diagnostic procedures), that the doctor or other staff member or clinician will notify me of the results at my next scheduled appointment.

☐ **NATURE OF CHIROPRACTIC TREATMENT**. I have been informed that, on occasion, some patients experience increased discomfort following chiropractic care and treatment. Chiropractic physical examination and treatment may involve bending, twisting, mechanically challenging your joints and testing your muscle strength, and it can possibly lead to temporarily feelings soreness or pain. During treatment, the doctor may use his or her hands or mechanical devices to move, adjust, manipulate your joints and mobilize soft tissues (e.g. muscles, ligaments). A "crack" or "pop" sound is often produced in some of the joint manipulation procedures and is caused by a separation of the smooth joint surfaces in much the same way a suction cup produces a popping sound when it is removed from glass or other smooth surface. Although a popping sound is not necessary, it is often a natural effect of joint movement.

☐ **PERMISSION FOR PHYSICAL CONTACT**. It has been explained to me, and I understand that, in the course of various chiropractic examination procedures and treatment methods, the doctor of chiropractic or other clinical staff may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment, and is prohibited. Nevertheless, I also realized that some chiropractic procedures may require that the doctor or clinician contact me in some physically sensitive areas – such as during a procedure known as a "lumbar roll" where the doctor may contact with my rump (the posterior, superior spine of the Ilium) to adjust my sacroiliac joint, or some other similar or analogous procedure. I understand, however, that before any sensitive contact or procedure occurs the doctor or other clinical staff member will explain to me ① what is to be done, ② how it will be performed, ③ why it will be performed, ④ that I may refuse that particular test or procedure, or alternatively that I may request that another member of the staff be present for my safety and protection, and finally, ⑤ that I will be given the opportunity to signal the doctor or clinician when I am ready to receive the test or procedure.

☐ I also agree that if I ever have any questions, doubts or misgivings about the appropriateness of such contact I can discuss my concerns with the doctor, or other office or clinical staff member. If for any reason I am reluctant to discuss these concerns directly with my doctor or clinician, or if I feel unsatisfied with the explanation given, I agree to seek a professional, third-party consultation from another licensed chiropractor mutually agreed upon by me and my chiropractor or clinician, or alternatively, I may contact the New York State Chiropractic Association (518-785-6346) or the state licensing agency – the New York State Education Department, State Board for Chiropractic (518-474-3817 X190). The doctor, clinician and I agree to these stipulations to ensure that no misunderstandings or uncomfortable feelings arise as a result of physical contact between me and the doctor or other office/practice clinician.

☐ Finally, it is my understand that I may revoke this permission at any time by a mutual exchange of written acknowledgments indicating that permission for any further physical contact by the doctor or other staff member with my person is prohibited. After having the foregoing information explained to me I hereby request, consent and submit to the office/practice's chiropractic examination and treatment methods performed as explained to me.

☐ **RISKS OF CHIROPRACTIC CARE AND TREATMENT**. I understand and have been informed that there is risk of side effects and complications anytime a doctor, provider or other clinician is asked to intervene in a healthcare encounter with a patient. I have been informed by the office/practice of the following: that although the risk of serious complication from chiropractic treatment is rare and unlikely, nonetheless, rare events ranging from relatively minor muscle soreness, aches, sprains and strains, to injuries to the spinal discs, nerves and cord, or an occasional fracture or dislocation in compromised patients with certain concomitant diseases and illnesses have been reported in the scientific literature; that cerebrovascular accidents, such as a stroke, have also been reported; that these are generally attributed to an underlying defect in a vertebral or basilar artery known as a spontaneous dissection and that these have been estimated to occur in one-to-a-million to one-in-forty-million cases of chiropractic, osteopathic, physical therapy and medical manipulation; about the same probability of stroke from turning your head or having your hair washed in a salon ("beauty parlor stroke'). In some of these instances, however, these dissections were not proximate in time or location to the treatment rendered, and consequently, it cannot be said with any certainty that the specific treatment caused the stroke, aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke.

☐ It was explained to me that the most common and likely side effect of treatment will be muscular stiffness or soreness, described by some as akin to the ache people experience after exercising the first time in a long time; and that these effects are often transient and temporary. I was instructed that if I experience any increased discomfort following treatment, that I should apply ice to, and rest the affected area. I was also told that if I become concerned about any post-treatment discomfort or, I should develop of any new or unrelated symptoms, I should call the number listed below for emergency attention available twenty-four (24) hours a day. I also understand that if for some reason I am unable to reach or contact that doctor, that I should telephone my personal, primary care doctor or present myself to the nearest hospital emergency room.

☐ It was explained to me and I do not expect the doctor to be able to anticipate all the potential risks or complications. Nor do I expect that the doctor or other clinician to provide me assurances that I will not experience a negative outcome. Nonetheless, I wish to rely on the doctor to exercise his or her best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time.

☐ **CONSENT**. By initialing each paragraph above in conjunction with the doctor, or other office or clinical personnel, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning. By signing below I agree to submit to the above named chiropractic examination and treatment methods. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment from the office/practice indicated below.

Signature _____ **Date** _____

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or 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 condition and related health care services.

USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office 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.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under 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 the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 have the right to request an amendment to your protected health information – 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 – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please note that by signing below you are only acknowledging that you have received a copy of our Notice of Privacy Practices.

Signature _____ **Date** _____