CHIROPRACTIC INTAKE & HISTORY

Meininger FAMILY CHIROPRACTIC

PATIENT INFORMATION

Patient ID #: _____ **Date:** _____

Patient Name _____
LAST NAME
_____
FIRST NAME Preferred Nickname

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐M ☐F Age: _____ Date of Birth: _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Childrens' Names & Ages _____

_____

Childrens' health concerns? _____

_____

Are you currently pregnant? □ No □ Yes, I am due _____

Have you seen a chiropractor before? □ No □ Yes, when? _____

Who may we thank for referring you? _____

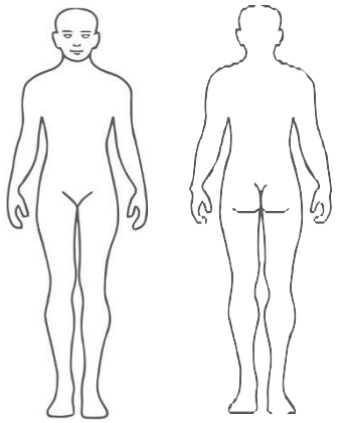
HOW CAN WE HELP YOU?

Health Concerns: List according to severity	Rate of Severity 1=Mild 10=Unbearable	How often do you have these symptoms?	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?
1.					
2.					
3.					

Please mark the areas on the diagram with the following letters to describe your symptoms:

What does it feel like?

- ☐ **N=** Numbness/Tingling
- ☐ **T=** Tight/Stiff
- ☐ **D=** Dull
- ☐ **A=** Aching
- ☐ **C=** Cramping
- ☐ **S=** Sharp/Stabbing/Shooting
- ☐ **B=** Burning
- ☐ Other _____



IMPACT OF YOUR SYMPTOMS

How are your health concerns interfering with your life? (Check where appropriate.)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

PATIENT WELLNESS ASSESSMENT

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

How committed are you to correcting this issue? (Please circle.)

NOT COMMITED 0 1 2 3 4 5 6 7 8 9 10 VERY COMMITED

HISTORY OF PHYSICAL TRAUMA

Please list past surgeries, adult & childhood injuries, and/or motor vehicle accidents

_____

_____

HEALTH & ILLNESS HISTORY

Please check the box next to any health concern you currently have or had in the past.

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues (Heart disease, high blood pressure/cholesterol)
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Dizziness
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Epilepsy
- ☐ Foot/Ankle Issues
- ☐ Headaches/Migraines
- ☐ Heartburn
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Neurologic Issues
- ☐ Neck Pain
- ☐ Reproductive Issues (Menstrual irregular/Fertility)
- ☐ Ringing in Ears/Earaches
- ☐ Scoliosis
- ☐ Sinus Issues
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

ALLERGIES, MEDICATIONS, & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

HIPAA Notice of Privacy Practices

Meininger Family Chiropractic
33 Lyman St. Suite 108
Westborough, MA 01581
(508) 898-2228

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 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.

1. Uses and 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 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 activities, employee review activities, training of medical students, licensing 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.
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 and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosure 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 physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative 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 protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. 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 described in this 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 physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information 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 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 we have made, if any, of your protected health information.**

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

3. 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 **March 14th, 2007.**

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 Phone Number.

Notice of Privacy Practices

We are concerned with protecting your privacy especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policy and procedures. We encourage you to read this document for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal information, we would be happy to address them.

I have received a copy of the HIPAA for Meininger Family Chiropractic.

_____ ____ /____ /____

Signature of Patient (or guardian if minor) Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understands both the objective and the method that will be used to attain it.

Adjustment – An adjustment is the specific application of forces that facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Subluxation – A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. *Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom.* Our only method is specific **adjustments** to correct vertebral subluxations.

I understand that I have the right to have all of my questions pertaining to the purpose of chiropractic care answered to my complete satisfaction prior to my first adjustment. I therefore accept any and all chiropractic adjustments on this basis.

If the patient is under the age of 18, I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

_____ ____ /_____ /_____

Signature of Patient (or guardian if minor) Date