Patient Demographics

First Name:_____ M.I.: _____ Last Name: _____

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

DOB: _____Phone:_____ Email:_____

Your Occupation:_____ Employer:_____ City: _____

Would your employer be interested in on-site Health and Wellness classes? □ YES □ NO

If yes, who would we speak to about setting up an events?_____

Marital Status:_____ Spouse's Name:_____

Do you have children?_____ Ages:_____ Have your children been seen by a chiropractor before? □ YES □ NO

Emergency Contact Name:_____ Phone #:_____

Primary Care Physician:_____

Insurance:_____ ID#:_____ Group #:_____

Primary Cardholder Relationship: □ Self □ Spouse □ Parent □ Other:_____

Primary Cardholder's Name: _____DOB: _____

How did you hear about Abundant Health Chiropractic?

□ Existing Patient: _____ □ Internet:_____ □ Ad (please specify):_____

□ Community Event: _____ □ Insurance Company □ Walk In □Other: _____

Patient Health History

Do you consume alcohol? □ Yes □ No How many drinks per day?_____ How often per week?_____

Do you smoke? □ Yes □ No _____ pk/day How many years have you smoked?_____

Do you exercise? □Yes □ No How often? _____x/wk Intensity of exercise: _____

Allergies:_____

Are You Pregnant? □ Yes □ No Date of Last Menstrual Period:_____

Please list surgeries and year:_____

List any recent accidents or falls and date:_____

Please list the medications that you are currently taking?_____

Have you ever received Chiropractic Care in the past? □ Yes □ No Last Visit Date?_____ X-Rays? □ Yes □ No

What is your primary complaint?_____

How long have you been experiencing this problem and symptoms?_____ □ days □ weeks □ months □ years

On a scale of 1 to 10, how severe are the symptoms at their worst? 1 2 3 4 5 6 7 8 9 10

What % of your awake time do you experience the symptoms? 0 10 20 30 40 50 60 70 80 90 100

What time of day are the symptoms the most acute? □ Morning □ Afternoon □ Evening □ Overnight

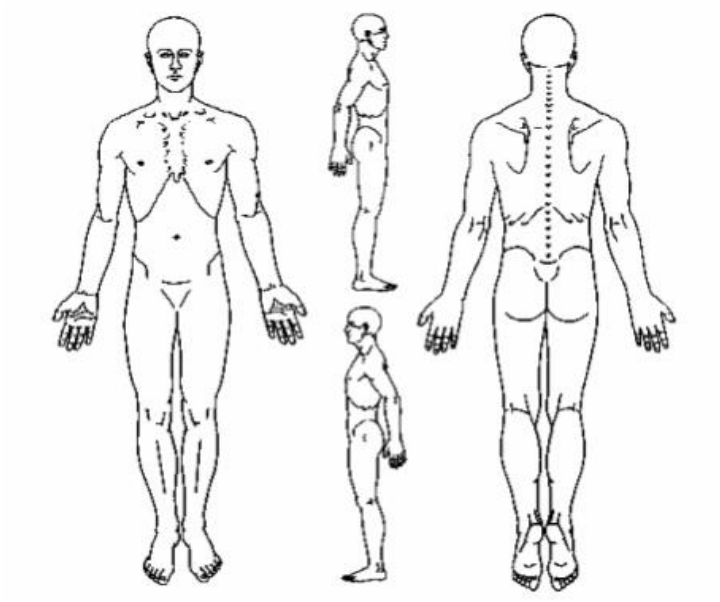
What makes the symptoms better?_____

What makes the symptoms worse?_____

For this problem, what treatments have you sought? □ None □ Hospitalized □ Another Chiropractor

□ Primary Physician □ Physical Therapy □ Other:_____

On the diagram below, label ALL areas you are experiencing symptoms using the appropriate letter from the symptoms listed: **A**=Aching **C**=Cramping **R**=Throbbing Pain **N**=Numbness **O**=Other **B**=Burning **D**=Dull Pain **S**=Stiffness **T**=Tingling **SH**=Sharp



Please indicate your symptoms with a C for CURRENT symptoms and a P for PAST symptoms.

_____ Arthritis
_____ Neck Pain
_____ Low Back Pain
_____ Upper/Mid Back Pain
_____ Shoulder Pain
_____ Hip Pain
_____ Foot / Ankle Pain
_____ Knee Pain
_____ Numbness /Tingling
_____ Tired Shoulders
_____ Swollen/Painful Joints
_____ TMJ Pain
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Heart Arrhythmias
_____ High Cholesterol
_____ Heart Attack
_____ Heart Disease
_____ Excessive Bleeding
_____ Allergies/Sinuses
_____ Trouble Sleeping
_____ Headaches

_____ Migraines
_____ Trouble Concentrating
_____ Dizziness
_____ Fainting
_____ Tremors
_____ Concussion
_____ Stroke
_____ Epilepsy
_____ Cancer
_____ Tumors
_____ Congenital Disease
_____ Learning Disability
_____ADD/ADHD
_____ Autism
_____ Ear Infections
_____ Bed Wetting
_____ Asthma
_____ Diabetes
_____ Loss of Balance
_____ Coughing Blood
_____ Pain with Cough/Sneeze
_____ Chest Pain

_____ Gallbladder
_____ Kidney Problems
_____ Ulcers
_____ Heartburn
_____ Diarrhea/Constipation
_____Colon Trouble
_____ Prostate Problems
_____ Menstrual Problems
_____ PMS
_____ Menopausal Problems
_____ Thyroid Problems
_____ Eating Disorder
_____ Mood Changes
_____ Depressed
_____ Alcoholism
_____ Drug Addiction
_____ HIV Positive
_____ Broken Bones List:
_____
_____

Do you have other health concerns, lifestyle issues, or interest that you would like to address?

□ Weight loss □ Quitting smoking □ Fitness □ Essential Oils
□ Detoxing your home □ Pet health □ Immune health □ Children's health
□ Enhancing athletic performance □ Customized vitamins/supplements

Other: _____

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THE DOCTORS OF CHIROPRACTIC AT ABUNDANT HEALTH CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____ _____

Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ **DOB:** _____

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

Remarks:

NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE) – Page 1

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information:

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious/imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE) – Page 2

In the case of fundraising:
We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:
We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:
We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:
We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:
We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:
We can use or share your information for health research.

Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:
We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Contact information: **Email:** office@docmeade.com
Effective Date of Notice: 01/01/2019

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

OPTIONAL:

1) May we confirm your appointments by email, text or phone? Yes No

2) May we leave a message on your answering device at home or cell phone? Yes No

3) May we discuss your condition with any members of your family? Yes No

If yes, provide names: _____

4) We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested. Are you comfortable being treated in an open room? Yes No

5) We offer Telehealth services. This type of communication is by live video conferencing. Are you comfortable with this type of communication if needed? Yes No

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____ _____
Patient Printed Name Patient Signature or legal representative

_____ _____
Date If legal representative, state relationship

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:
___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details):

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date