Health History

Name: _____ DOB: _____ Date: _____

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

Email: _____ Occupation: _____

Phone: _____ Cell: _____ Work Phone: _____

Married Single Divorced Widowed Kids: _____

Referred By: _____

Childhood History: *Circle all that apply*

Did you have any childhood illnesses?	Yes	No
Did you have any serious falls as a child?	Yes	No
Did you play youth sports?	Yes	No
Did you take Medications?	Yes	No
Did you have surgery?	Yes	No
Have you fallen / jumped from a height over three feet?	Yes	No
Were you in any car accidents as a child?	Yes	No
Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No
Did you suffer any other traumas (physical or emotional)	Yes	No
As a child, were you under regular chiropractic care?	Yes	No

Please share any additional information:

_____

_____

Adult – (18 to present)

Do/did you smoke? **Yes** **No**

Do/did you drink alcohol? **Yes** **No**

Have you been in any accidents? **Yes** **No**

Have you had any surgery? **Yes** **No**
If yes, list here: _____
_____

Do/did you play adult sports? **Yes** **No**

_____

On a scale of 1 – 10 describe your stress level:
(1 = none / 10 = extreme)

Occupational: _____ Personal: _____

Rate these following as Poor, Good, Excellent:

Diet: _____ **What do you eat?** _____

Exercise: _____ **When and what?** _____

Sleep: _____ **Hours per day?** _____

General Health: _____

Please list any medications: _____

_____

_____

Addressing issues that may have brought you to our office

If you have no symptoms or complaints, and are here for wellness services, please check here: _____ and then skip to Family Health Profile. Otherwise please briefly explain what brought you to our office today:

_____

_____

Does this interfere with: ___ Work ___ Sleep ___ Walking ___ Hobbies ___ Leisure ___ Other

Have you seen anyone else for this issue? ____ yes _____ no If yes, who? _____

_____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

Family Health Profile:

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brother(s): _____

Sister (s): _____

Others: _____

Do you:

Drink Bottled water?	Yes	No	
Belong to health club?	Yes	No	
Use vitamins?	Yes	No	
Watch more than 5 hours of TV a week?	Yes	No	
Spend 1 or more hours on a computer daily ?	Yes	No	
Drink Soda?	Yes	No	(Diet or Regular)

What do you do for stress relief?

_____

_____

How many times a week do you exercise? What type of exercise do you do?

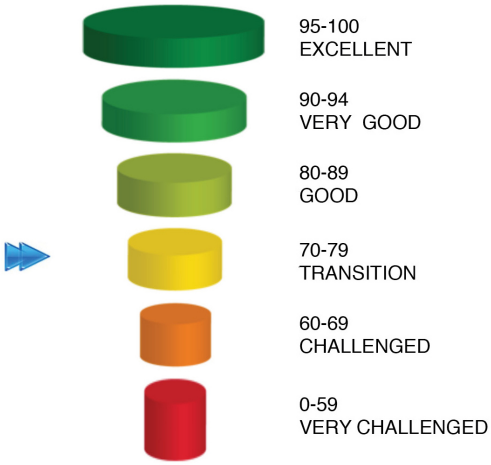
_____

Are there any other health habits that you could share with us?

_____

_____

Please mark an "X" where you believe your health is and an "O" where you would like to be.



I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature _____ Date: _____

Cape Ann Community Chiropractic

New Patient Agreement

Cape Ann Community Chiropractic is a 501(c)3 Non-profit Charity Organization formed under the belief that *chiropractic is a healthcare necessity for all*, for the preservation and maintenance of health and the optimization of human potential. We do not accept insurance because we specialize in wellness care and the elevation of human potential, rather than pain management alone. Cape Ann Community Chiropractic eliminates barriers to all people receiving excellent chiropractic care by providing income-based payment options in-office and no-charge outreach clinics to provide care to those in need, including those experiencing homelessness and drug dependency. Chiropractic is by definition drug-free, saludogenic healthcare. Rather than treating disease with "a pill for every ill", chiropractic's focus is to promote and enhance the healing power within the body's own nervous system.

Read and initial each statement.

- I understand that by receiving care at this clinic, I am not only caring for my own health, but am a part of a movement to elevate our human potential as a community.

  _____

- I understand that if I am ever experiencing hardship, there are options available for me, and it is not a barrier to following the care plan recommended by my doctor.

  _____

- I give permission to be contacted via phone call, text, or e-mail with information relevant to my healthcare. (*Circle which you prefer.*)

  _____

- I understand that consistency and commitment is important to my success in meeting my goals. If I am unable to make an appointment and fail to give notice 24 hours in advance, my card on file will be charged a $25.00 missed appointment fee.

  _____

Credit/Debit Card Payments

Cardholder Name: _____ Exp. Date _____ CSC#_____

Card Number: _____ Visa/Mastercard/Am Ex./Disc.

Cardholder signature: _____ Zip: _____

PATIENT'S SIGNATURE _____ Date: _____

ERIN O'MALEY, D.C.
CAPE ANN COMMUNITY CHIROPRACTIC

Informed Consent for Treatment

Chiropractic healthcare is a science, art, and philosophy that is concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurological evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on structural and/or functional abnormalities called "subluxation". Subluxation exists when one or more vertebrae in the spine or bones in the extremity are misaligned sufficiently enough to result in damage or irritation to either the nearby nerves, joints, and/or tissues. The primary goal of chiropractic treatment is the removal of subluxation(s). This is accomplished by performing a procedure unique to the chiropractic profession called an "adjustment". A chiropractic adjustment involves the application of a quick, precise force by hand or by instrument directed over a very short distance to a specific vertebra or bone. In addition to adjustments, other treatments may include physiotherapy modalities (e.g. heat, ice, ultrasound, soft tissue manipulation), nutritional recommendations, and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care.

One research study indicated that approximately half of patients reported an adverse reaction to chiropractic treatment shortly after initiating care. Most appeared within 4 hours of treatment and resolved within 24 hours. These were:
Local discomfort (53%)
Headache (12%)
Tiredness (11%)
Radiating discomfort (10%)

Rare, yet possible, complications exist, including the following:
- Rib fracture
- Disc herniation

Thoroughness in reviewing your history and exam is to determine what risk, if any, chiropractic treatment may pose to you and advise you of those risks as well as the possible need for medical referral.

While under Chiropractic care, our patients have experienced many beneficial side-effects. The following is a list of the most common things chiropractic patients notice.

Less pain, greater comfort
Increased energy
Better sleep
Improved digestion
Less allergies and sinus trouble
Reduced ear infections
Ease PMS & menstrual cramps
Improved digestion
Decreased drug use
Improved mood
More ease under stress
Fewer head colds and bugs
More mobility
Improved immunity
More focus and clarity
Breathe easier, asthma reduction
Reduced headaches
Increased flexibility and coordination
More longevity at work and play
Stimulates other healthy choices

I have read the previous information regarding the potential risks of chiropractic care. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT'S SIGNATURE _____ **Date:**

PARENT/GUARDIAN _____ **Date:**
(if appropriate)

DOCTOR'S SIGNATURE _____ **Date:**

HIPAA Authorizations & Acknowledgement

Appointment Reminders & Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. Contact may take the form of an e-newsletter. Contact may also be by postcard offering a free preventative check-up or a free office visit. By signing this form, you are giving us authorization to contact you with these reminders and information.

- You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.
- Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be subject to federal privacy rules.
- You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide you or the methods we use to obtain reimbursement for you care.
- You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other related health information at any time. (164.524)
- This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.
- I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient signature (or representative's): _____ Date: _____

Privacy Notice Acknowledgement

We are very 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 policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosures of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

- I acknowledge that I have received a copy of Dr. O'Maley's Notice of Privacy Practices for Protected Health Information:

Patient signature (or representative's): _____ Date: _____