

Whom may we thank for referring you to this office? _____

Practice Member Intake Form For Care at J&M Family Chiropractic

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

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

_____ E-mail Address: _____ Home Phone: _____ Mobile _____

Phone: _____ Marital Status: Single Married Do you have Insurance: Yes No

Work Phone: _____ Social Security #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary: _____ Secondary: _____ Third _____ Fourth _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

WHEN did the problem(s) begin? give a Date (ex. 12/21/1995) _____

HOW did this Problem Begin _____

When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

Condition(s) ever been treated by anyone in the past? ___ NO ___ Yes: If yes, when? _____ By whom? _____

What were the results _____ How long were you under care? _____

Name of Previous Chiropractor: _____ N/A

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating

B = Burning

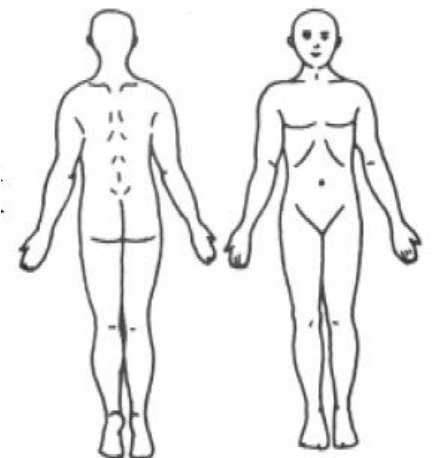
D = Dull

A = Aching

N = Numbness

S = Sharp/Stabbing

T = Tingling



Is your problem the result of ANY type of accident? Yes No Motor vehicle accident (MVA) ___ Yes ___ No, if yes when _____
Workers Comp ___ Yes ___ No, if yes when _____ Are you still in litigation ___ Yes ___ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes**, how many times? _____ When was the last episode? _____ How did the injury happen?

Other forms of treatment tried: No Yes **If yes**, please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____ What were the results. Favorable Unfavorable → please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently**:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability

___ Cancer ___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular

___ Other serious conditions: _____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your PRESENT problem:

HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →		
SURGERIES →		

SOCIAL HISTORY

- Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never
- Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never
- Recreational Drug use:** Daily Weekends Occasionally Never
- Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

FAMILY HISTORY:

- Does anyone in your family suffer with the same condition(s)? No Yes
If yes whom: grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)
Have they ever been treated for their condition? No Yes I don't know
- Any** other hereditary conditions the doctor should be aware of? No Yes: _____

I hereby authorize payment to be made directly to J&M Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to J&M Family Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor/Team Member Signature

____ - ____ - ____
Date Form Reviewed

PATIENT'S NAME: _____ Date: _____

ACTIVITIES OF LIFE/DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY	Effect
<input type="checkbox"/> Carry/lift children/groceries _____ lbs	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Sit to stand	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Climb Stairs	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Read/concentrate _____ min/hr	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Getting Dressed	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Static Sitting _____ min/hr	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Yard work	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Walking: out of breath/muscle pain _____ min/hr	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Washing/Bathing	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Household Chores	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Turning Head while Driving	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Other _____ min/hr	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
<input type="checkbox"/> Static Standing _____ min/hr	<input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform

Please mark **C** for **Currently** have (< 1 month) if not current leave blank.

_____ Headaches/migraines _____ # (frequency) describe _____	_____ Dizziness	_____ Ulcers
_____ Neck Pain	_____ Loss of Balance	_____ Digestive Problem
_____ Jaw Pain/TMJ/Grind teeth at night	_____ Fainting	_____ Diarrhea/Constipation
_____ Shoulder Pain: Left Right	_____ Double Vision	_____ Heartburn/Ageda/acid reflux
_____ Back Pain: Upper Lower	_____ Blurred Vision	_____ Heart Problem
_____ Hip Pain: Left Right	_____ Ringing in the Ears/Tinnitus	_____ High Blood Pressure/hypertension
_____ Numb/Tingling: arms hands fingers	_____ Hearing Loss: Left Right	_____ Low Blood Pressure/hypotension
_____ Numb/Tingling: legs feet toes	_____ Depression	_____ Asthma
_____ Allergies: Food or seasonal	_____ Irritable	_____ Breathing Difficulty
_____ Pregnant (Now)	_____ ADD/ADHD	_____ Kidney Trouble
_____ Frequent Colds/Flu	_____ Learning Disorder	_____ Gall Bladder Trouble
_____ Convulsions/epilepsy	_____ Prostrate Problem	_____ Liver Trouble
_____ Tremors	_____ Impotence/Erectile Dysfunction	_____ Hepatitis A B C
_____ Chest Pain	_____ Bed Wetting	
_____ Foot Problems	_____ Menopausal Problem	
_____ Knee problems	_____ Menstrual/PMS Problem	
_____ Sinus Problems		
_____ Trouble Sleeping _____ # interruptions		

List Prescription & Non-Prescription drugs you take: _____

Patient signature: _____ Today's Date: ___/___/___

PATIENT'S NAME: _____ Date: _____

J&M Family Chiropractic

226 Main Street North, Woodbury, CT, 06798

203.586.1466

Fax 203.586.1477


REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ / ____ / ____  *Witness Initials*
Patient or Authorized Person's Signature

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at **J&M Family Chiropractic** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ / ____ / ____  *Witness Initials*

J&M Family Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call (Dr. Melissa Beck) at (203) 586-1466. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____

(J&M Family Chiropractic) NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of **(J&M Family Chiropractic)** Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Print Patient's Name

Birth Date (DOB)

Patient's Signature

Today's Date

Witness

Today's Date