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**

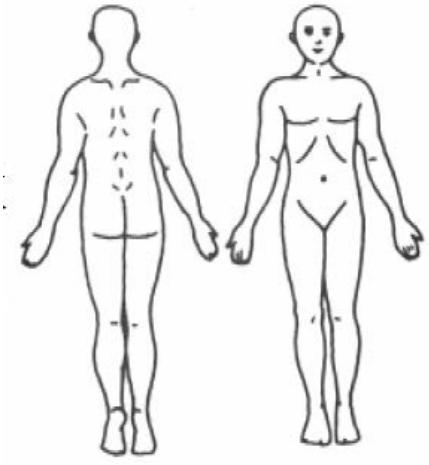
What relieves your symptoms? _____

What makes your symptoms feel worse? _____

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

R = Radiating **B = B**urning **D = D**ull **A =** Aching

N = Numbness **S = S**harp/**S**tabbing **T= T**ingling



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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

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. 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

2. 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	
☐ Carry/lift children/groceries _____ lbs		☐Painful (limits)	☐Unable to Perform
☐ Sit to stand		☐Painful (limits)	☐Unable to Perform
☐ Climb Stairs		☐Painful (limits)	☐Unable to Perform
☐ Read/concentrate	_____ min/hr	☐Painful (limits)	☐Unable to Perform
☐ Getting Dressed		☐Painful (limits)	☐Unable to Perform
☐ Static Sitting	_____ min/hr	☐Painful (limits)	☐Unable to Perform
☐ Yard work		☐Painful (limits)	☐Unable to Perform
☐ Walking: out of breath/muscle pain	____min/hr	☐Painful (limits)	☐Unable to Perform
☐ Washing/Bathing		☐Painful (limits)	☐Unable to Perform
☐ Household Chores		☐Painful (limits)	☐Unable to Perform
☐ Turning Head while Driving		☐Painful (limits)	☐Unable to Perform
☐ Other _____	_____min/hr	☐Painful (limits)	☐Unable to Perform
☐ Static Standing	_____min/hr	Painful (limits)	Unable to Perform

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

_____ Headaches/migraines _____#(frequency)describe_____

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

List Prescription & Non-Prescription drugs you take: _____

_____

Patient signature: _____ **Today's Date:** __/__/__

PATIENT'S NAME: _____ Date: _____

PREGNANCY HISTORY FORM FOR J&M FAMILY CHIROPRACTIC

PATIENT DEMOGRAPHICS Today's Date _____/_____/____

Baby's Name_____

Pediatrician/Family MD/OBGYN/Midwife/Doula _____

Hospital/Birthing Center_____

City/State _____

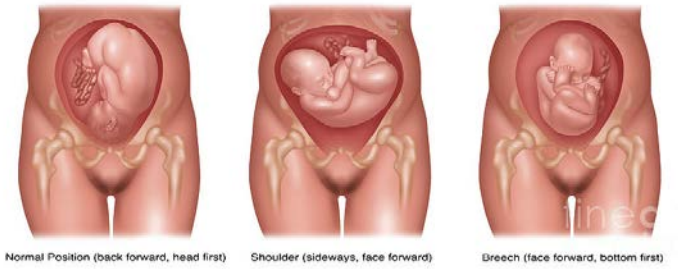
Last Visit: ____/____/____ Reason for visit:_____

DUE DATE_____

Pregnancy: Please circle below

Purpose of this visit: Breach Vaginal Birth after C-Section(VBAC) Wellness

If Breach, Please Circle:



OTHER: Please explain: _____

Goals:_____

Is this your first pregnancy? Yes No

If no, how was your first pregnancy?

Birth Location: Home Birth Hospital Birth Birthing Center

Active Labor Time: <4 hrs > 4 hours > 10 hours > 1 day >2 days

Pushing Time: <10 min 10-30 min >30 min

Birth Type: Natural (no meds) Vaginal Birth Forceps Vacuum extraction

Pitocin epidural C-section

If C-section, reason for C section?_____

_____

_____ _____ _____

Practice Member Signature Team Member/Doctor Signature Date

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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 **P**ersonal **H**ealth **I**nformation. 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 apprize 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