

CHIROPRACTIC CONNECTION CENTER

NEUROLOGICALLY BASED CHIROPRACTIC CARE

120 South Woodland Boulevard • Suite B • DeLand, FL 32720 • Phone:(386) 734-1404

Patient Information

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First Name

Middle Name

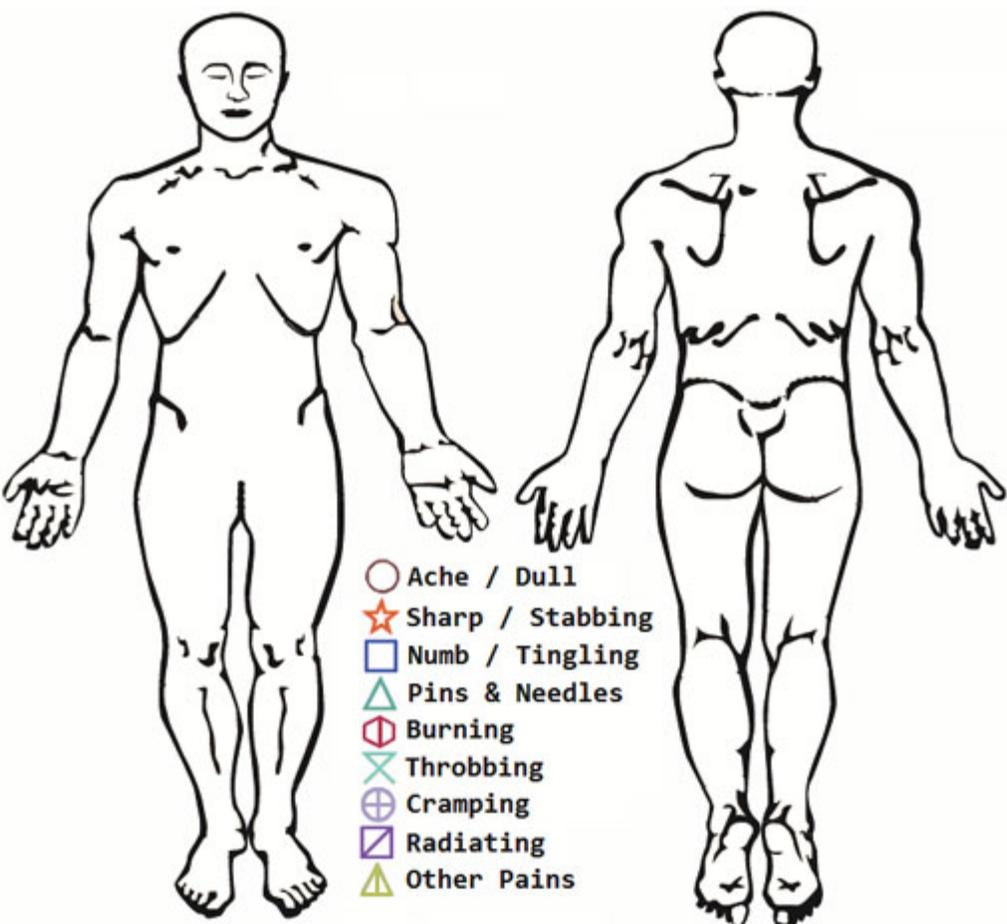
Last Name

Date

Address: _____
City/St/Zip: _____
Cell #: _____
Home #: _____
Work #: _____
Email: _____
Birth Date: _____ Sex: Male Female

Employer: _____
Occupation: _____
Referred By: _____
Emergency Contact: _____
Emergency Relation: _____
Emergency Phone: _____

Patient Symptoms



○ Ache / Dull
★ Sharp / Stabbing
□ Numb / Tingling
△ Pins & Needles
◇ Burning
× Throbbing
⊕ Cramping
▣ Radiating
▲ Other Pains

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Complaint Information

Injury Occurred: Work Automobile Third-Party Other Injury Date: _____

Injury Origin: _____

Describe Discomfort: _____

Interfere w/ Activities: Yes No Affected Sleep: Yes No Frequency: _____

Missed Work: Yes No Unable to Work from: _____ Until: _____

Affected Appetite: Yes No Explain: _____

Reduced Work: Yes No Explain: _____

Does it Worsen: Yes No Explain: _____

Weather Affects it: Yes No Explain: _____

What Aggravates Condition: _____

What Improves Condition: _____

Received Treatment: Yes No Explain: _____

X-rays Taken: Yes No Explain: _____

Same Condition Before: Yes No Date: _____ Practitioner: _____

For Women Only

Are you pregnant? Yes No Are you taking birth control? Yes No Do you have irregular cycles? Yes No

Are you nursing? Yes No Do you have painful periods? Yes No Do you have breast implants? Yes No

Personal Health History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: Yes No Date: _____ Condition(s): _____

Chance Pregnant: Yes No Planning: Yes No

Medications: _____

Supplements: _____

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Personal Incident History

Broken Bones:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain _____
Sprain Strains:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain _____
Hospitalized:	<input type="radio"/> Yes <input type="radio"/> No	Explain _____		
Surgery:	<input type="radio"/> Yes <input type="radio"/> No	Explain _____		
Auto Accident:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain _____
Struck Unconscious:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain _____
Eating Disorder:	<input type="radio"/> Yes <input type="radio"/> No	Explain _____		
Stroke:	<input type="radio"/> Yes <input type="radio"/> No	Explain _____		

Health Checklist

<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Constipation	<input type="checkbox"/> Cramps
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Digestion Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Excessive Menstruation	<input type="checkbox"/> Eye Pain or Difficulties
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Headache
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Irregular Menstrual	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Polio	<input type="checkbox"/> Poor Posture
<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Spinal Curvatures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Varicose Veins	

Family Health History

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Informed Consent

Medical doctors, chiropractic doctors, and osteopathic doctors who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjusting is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware, that like exercise, it is common to experience muscle soreness after the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases, underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc disease, or other abnormality is detected, extra caution will be exercised during treatment.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I am aware that there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened muscles and bones, and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient or Guardian

Date

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Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

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

- 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.
- If you pay for a service or health care item out-of-pocket 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.

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 using the information on page the next page (2) / back page.
- 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 and 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
- Most 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.

OUR USES AND DISCLOSURES

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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 you 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 workers’ 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 health 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 the 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, in our office, and on our web site.

Effective Date: September 23, 2013

I have read and understand the HIPAA notice of privacy policies and am aware of my rights under these regulations.

Signature of Patient or Guardian

Date