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

APPLICATION FOR CARE AT EASTERN SHORE CHIROPRACTIC & SPORTS CLINIC

PATIENT DEMOGRAPHICS

Today's Date: _____-_____-_____

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

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

E-mail Address: _____ Marital Status: ❑ Single ❑ Married

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Do you have Insurance: ❑ Yes ❑ No Insurance provider: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and Ages: _____

Emergency Contact: _____Phone number: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:
Primary complaint to be evaluated: _____
Secondary complaint to be evaluated: _____

Date problem(s) began? _____

Please describe the onset (How did it happen?)_____

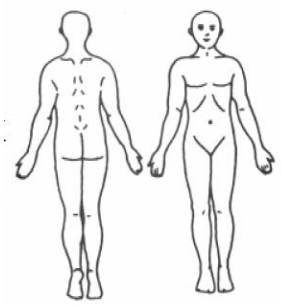
Is your problem the result of ANY type of vehicle or work related injury? ☐ Yes, ☐ No
If yes, please describe: _____

Are your condition(s) currently being treated by anyone? ☐No ☐ Yes If yes, by whom? _____
If yes, do we have permission to forward your records to them? ☐No ☐ Yes

Have your **c**ondition(s) been treated by anyone in the past? ☐No ☐ Yes
If yes, when: _____ by whom? _____
How long were you under care: _____ What were the results? _____
Name of Previous Chiropractor: _____ ☐ **N/A**

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

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



On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*****:**
Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What relieves your symptoms? _____

What makes them feel worse? _____

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

_____

_____

ACTIVITIES OF LIFE

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

ACTIVITIES	EFFECT									
	No Effect ←									→ Unable to perform
	0/10	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10
Bending	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Carrying Groceries	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Sit to Stand	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Climbing Stairs	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Driving	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Extended Computer Use	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Lifting	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Static Sitting	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Static Standing	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Yard work	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Walking	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Running	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
Example: sitting, driving, working, bending	**15 minutes before pain limits my ability**	**unlimited**
Example: running, cycling, exercising	**5 minutes before pain limits my ability**	**30 – 60 minutes**
_____:	_____	
_____:	_____	

PAST HISTORY

Have you suffered with any of this or a similar condition in the past? ❑ No ❑ Yes **If yes** how many times? _____

When was the last episode? _____ How did the injury happen?_____

Have you tried any other forms of treatment? : ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____

Who provided it: _____ How long ago? _____What were the results. ☐ Favorable ☐ Unfavorable

Please explain: _____ _____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***currently*** have and **N** for ***Never** have had*:

___ 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 →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

Please mark P for in the Past, C for Currently have and N for Never

___ Headache ___ Pregnant (Now) ___ Dizziness ___ Prostate Problems ___ Ulcers

___ Neck Pain ___ Frequent Colds/Flu ___ Loss of Balance ___ Impotence/Sexual Dysfun. ___ Heartburn

___ Jaw Pain, TMJ ___ Convulsions/Epilepsy ___ Fainting ___ Digestive Problems ___ Heart Problem

___ Shoulder Pain ___ Tremors ___ Double Vision ___ Colon Trouble ___ High Blood Pressure

___ Upper Back Pain ___ Chest Pain ___ Blurred Vision ___ Diarrhea/Constipation ___ Low Blood Pressure

___ Mid Back Pain ___ Pain w/Cough/Sneeze ___ Ringing in Ears ___ Menopausal Problems ___ Asthma

___ Low Back Pain ___ Foot or Knee Problems ___ Hearing Loss ___ Menstrual Problem ___ Difficulty Breathing

___ Hip Pain ___ Sinus/Drainage Problem ___ Depression ___ PMS ___ Lung Problems

___ Back Curvature ___ Swollen/Painful Joints ___ Irritable ___ Bed Wetting ___ Kidney Trouble

___ Scoliosis ___ Skin Problems ___ Mood Changes ___ Learning Disability ___ Gall Bladder Trouble

___ Numb/Tingling arms, hands, fingers ___ ADD/ADHD ___ Eating Disorder ___ Liver Trouble

___ Numb/Tingling legs, feet, toes ___ Allergies ___ Trouble Sleeping ___ Hepatitis (A,B,C)

List Any and All Prescription & Non-Prescription drugs you take:

_____

_____

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. How does your present problem affect the following: Hobbies -Recreational Activities- Exercise Regime?

_____

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 EASTERN SHORE CHIROPRACTIC AND SPORTS CLINIC, 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 Eastern Shore chiropractic and Sports clinic for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor/Staff's Signature **Date Form Reviewed**

EASTERN SHORE CHIROPRACTIC AND SPORTS CLINIC

Authorization for Verbal Communication, to Leave Voicemail Messages, and/or Receive Emails Regarding My Personal Health Information

This does not authorize release of medical records without a signed authorization to release medical records by patient or guardian

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____-_____-_____

INFORMATION TO BE DISCLOSED: Verbal communication only regarding patients care-no copies of medical records provided

PLEASE PROVIDE YOUR CURRENT TELEPHONE NUMBERS:

Home Phone: _____ Cell phone: _____

Work Phone: _____ Other Phone: _____

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday. Please check below where you would prefer to be contacted during these hours:

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Other Phone: _____

If we need to contact you after hours, please check below where you prefer to be called:

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Other Phone: _____

YOUR PROTECTED HEALTH INFORMATION DESIGNEES:

If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information. This person (designee) will also be able to call the office on your behalf.

PLEASE PRINT THE NAME AND RELATIONSHIP TO YOU/PATIENT OF EACH DESIGNEE BELOW:

Designee Name: _____ Relationship to patient: _____

Designee Name: _____ Relationship to patient: _____

Designee Name: _____ Relationship to patient: _____

_____ **CHECK HERE IF YOU *DO NOT* WANT YOU HEALTH CARE INFORMATION DISCUSSED WITH ANYONE OTHER THAN YOURSELF.**

CONFIDENTIAL VOICEMAIL

PLEASE CHECK BELOW WHERE WE HAVE YOUR PERMISSION TO LEAVE A CONFIDENTIAL VOICEMAIL:

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Other Phone: _____

CONFIDENTIAL EMAIL

PLEASE WRITE BELOW AN EMAIL ADDRESS THAT WE CAN SEND EDUCATIONAL INFORMATION PERTAINING TO YOUR TREATMENT PLAN/GOALS (STRETCHES, EXCERSICES, ETC.):

_____

YOUR SIGNATURE BELOW CONFIRMS YOUR APPROVAL OF THESE UPDATED HIPAA COMMUNICATIONS PREFERENCES. YOU MAY CHANGE YOUR SELECTIONS AT ANY TIME, BUT MUST DO SO IN WRITING BY COMPLETEING AN UPDATED FORM.

Patient Signature: _____ Date: _____-_____-_____

Witness: _____ Date: _____-_____-_____

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 Eastern Shore Chiropractic and Sports Clinic 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*

Patient or Authorized person's Signature Date

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 Date

JDD,DC 5/2011

Eastern Shore Chiropractic & Sports Clinic 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. Each patient is given a copy of **'HIPAA'** notice of privacy practices with your paperwork on your first appointment. 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 Kay at 251-990-8383. 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: _____**-retaining page 1 of 2***

Eastern Shore Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Eastern Shore Chiropractic and Sports Clinic's Patient Privacy Notice. I understand my rights as well as the practices 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 an 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.

_____	_____	_____
Patient's Name	DOB	HR#

_____	_____
Patient signature	Date

_____	_____
Witness	Date

JDD,DC 5/2011

OFFICE POLICY

We believe that a clear definition of our office policies will allow YOU, the patient, and Us, the doctor, to concentrate on the big issue – **REGAINING AND MAINTAINING YOUR HEALTH**.

APPOINTMENT POLICY

Multiples appointments have been scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts, not the days. Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within 7 days of any cancellation. This office reserves the right to charge ($50.00) for missed appointments and those cancelled without 24-hour notice.

When entering the office on any given visit, please go directly to the front desk and "sign-in". We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for next available appointment.

FINANCIAL POLICY

1. It is our policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments whether or not the office accepts insurance assignment.

2. All payments are expected at the time of services or at the end of the week. Patient balances may not exceed $150.00 at any time.

3. All insurance assignment patients must pay their deductible in full and the co-pay/co-insurance at the time of service or at the end of the week.

4. There will be a $35.00 fee imposed for all checks returned to this office.

5. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for missed appointments and those ,cancelled without a 24 hour notice.

A detailed policy manual has been given to me. I have read and understand all the policies.

Signature _____ Date_____

I have been informed and understand the privacy notice explaining my personal health care information.

Signature_____Date_____