

ABRAMS

ACUPRESSURE & CHIROPRACTIC

Patient Information

Today's Date: ___ / ___ / ____

First Name: _____

Nickname: _____ Middle Name: _____

Last Name: _____

Date of Birth: ___ - ___ - ____ Age: ____

Gender: Male Female Unspecified

Marital Status: M S W D # of Children: _____

SSN: ___ - ___ - ____

Address 1: _____

Address 2: _____

City/State/Zip: _____

Primary Phone: () _____ - _____

Secondary Phone: () _____ - _____

Mobile Phone: () _____ - _____

Employment Status: Employed FT Student

PT Student Other Retired Self-Employed

Employer (if applicable): _____

Home Email: _____

Work Email: _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Preferred Contact Method: Primary Phone

Secondary Phone Mobile Home Email

Work Email

Referred by: _____

Signature: _____

Race: Black/African American Hispanic

White Asian Indian Chinese

Asian Korean Vietnamese

Japanese Guamanian or Chamorro Filipino

Samoan Native Hawaiian or other Pacific Island

American Indian/Alaskan Native I choose not to specify

Multi-Racial: Yes No Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Latino

I choose not to specify

Preferred Language: English Spanish Chinese Russian

Armenian French German Tagalog Italian

Portuguese Korean Arabic Polish Japanese

French Creole Hindi Persian Urdu Gujarati

American Sign Language Greek I choose not to specify

Do you currently smoke tobacco of any kind? Yes

Former smoker Never been a smoker

If yes, how often do you smoke? Current every day smoker

Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

0 1 2 3 4 5 6 7 8 9 10

No Interest

Very Interestet

Security Question (choose only one question, then give the answer to

that question): What is the name of your favorite pet?

In what city were you born? What high school did you attend?

What is the name of your favorite movie? What is your mother's

maiden name? On what street did you grow up? What was the make

of your first car? When is your anniversary?

Security Answer: _____

must be at least 6 characters long

Current medications, including frequency and dosage if known. If there are no current medications, check here:

1. _____ Start Date: ___ / ___ / ____ 5. _____ Start Date: ___ / ___ / ____

2. _____ Start Date: ___ / ___ / ____ 6. _____ Start Date: ___ / ___ / ____

3. _____ Start Date: ___ / ___ / ____ 7. _____ Start Date: ___ / ___ / ____

4. _____ Start Date: ___ / ___ / ____ 8. _____ Start Date: ___ / ___ / ____

List any known allergies you have had to medications. If no allergies are known, check here:

1. _____ 3. _____

2. _____ 4. _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-Ray, CT Scan, or MRI of your LOW BACK spine in the past 28 days? Yes No

Patient First Name: _____ Last Name: _____ MI: _____

Confidential Case History

Please complete this questionnaire. Your answers will help us determine if Chiropractic can help you.

If we sincerely believe your condition will not respond satisfactory to treatment, we will not accept your case.

What is your major complaint? _____

Do you have any other complaints? _____

When did this begin? _____

Since the condition started has it gotten better, same or worse? _____

Have you had the same or similar conditions in the past? _____

Is there anything that makes your condition *worse*? _____

Is there anything that makes your condition *better*? _____

Select all that describe your pain: constant aggravated by movement come & go getting worse staying the same

Select all experiences that you have related to this pain: weakness radiating pain dizziness numbness blurred vision vomiting

nausea burning pins & needles dull & aching sharp (if so please explain): _____

Pain Level Chart

please indicate the pain level you are currently experiencing

no pain

unbearable pain

0 1 2 3 4 5 6 7 8 9 10

*please select all the activities that you find difficult to do **now** due to your discomfort*

- | | | |
|--|--|--|
| <input type="checkbox"/> sleep through the night | <input type="checkbox"/> crawl on all fours | <input type="checkbox"/> push or pull vacuum or lawn mower |
| <input type="checkbox"/> get out of bed | <input type="checkbox"/> carry laundry basket, groceries or child | <input type="checkbox"/> turn door knob |
| <input type="checkbox"/> make your bed | <input type="checkbox"/> open a heavy door | <input type="checkbox"/> wash windows or walls |
| <input type="checkbox"/> bathe yourself | <input type="checkbox"/> sit in a chair for 30 minutes | <input type="checkbox"/> shovel snow or dirt |
| <input type="checkbox"/> wash, comb or dry hair | <input type="checkbox"/> sit and work at a desk for one hour | <input type="checkbox"/> bend over to clean bathtub |
| <input type="checkbox"/> bend over a sink for more than 10 minutes | <input type="checkbox"/> use pencil, scissors, screwdriver or pliers | <input type="checkbox"/> get up from a low seat |
| <input type="checkbox"/> go to the bathroom | <input type="checkbox"/> cross legs | <input type="checkbox"/> lift heavy suitcase (about 40 lbs.) |
| <input type="checkbox"/> put on socks, shoes or clothing | <input type="checkbox"/> reach in front or overhead to high shelves | <input type="checkbox"/> walk for one mile |
| <input type="checkbox"/> walk up one flight of stairs | <input type="checkbox"/> stand for 30 minutes | <input type="checkbox"/> enjoy hobbies or social activities |
| <input type="checkbox"/> walk down one flight of stairs | <input type="checkbox"/> travel on journeys that take over one hour | <input type="checkbox"/> enjoy sexual activities |

Are there any of the above activities that you had a difficult time doing **before** you had this discomfort? _____

please select the problem area(s) or condition(s) you have experienced

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tight/Sore Muscles | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Sinus/Allergy | <input type="checkbox"/> Leg & Hip | <input type="checkbox"/> Numbness (Hands/Feet) | <input type="checkbox"/> Low-Back Pain |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Loss of Energy | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Stressed Shoulders | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Wrist or Joint Pain | <input type="checkbox"/> Sports Injury |
| <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Chemical Stress | <input type="checkbox"/> Physical Stress | <input type="checkbox"/> Emotional Stress |

How long has it been since you really felt good?

Do these conditions disrupt?

What methods have you tried?

List other doctors who have treated this condition:

Career/Work

Exercise

Family Life

Physical Therapy

Ability to Exercise

Prescription Drugs

Sleeping Patterns

Massage

Social Life

Chiropractic

Nothing

Please list any surgeries and dates: _____

Have you ever been in an accident or personal injury? yes no When? _____ Describe: _____

Insurance Agreement

Patient Agreement Assignment & Release: I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Abrams all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient/Guardian Signature: _____ **Date:** ___ / ___ / ___

Insured's First Name: _____ MI: _____ Last Name: _____

Insured's Date of Birth: ___ - ___ - _____ Insured's ID #: _____ Group #: _____

Do you have a secondary insurance? yes no If yes, name: _____

Cash Agreement

Patient Agreement: I, the undersigned, will be a cash paying patient and understand that I am financially responsible for all charges incurred for examinations, consultations, and treatment rendered. I authorize Dr. Abrams to provide these services to _____.

Patient/Guardian Signature: _____ **Date:** ___ / ___ / ___

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health concerns that you may have for those members:

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient/Guardian Signature: _____ **Date:** ___ / ___ / ___

To Be Performed By Clinic Staff:

Height: _____ inches Weight: _____ pounds BP: _____/_____

NOTICE OF PRIVACY PRACTICES

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning

your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time. We realize that these laws are complicated, but we must provide you with the following important information:

· How we may use and disclose your IIHI, your privacy rights in your IIHI, our obligations concerning the use and disclosure of your IIHI. The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

B. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and therapists, or indirectly with any provider we refer you to - may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child’s medical information.
8. Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

C. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
 - Maintaining vital records, such as births and deaths, reporting child abuse or neglect, preventing or controlling disease, injury or disability, notifying a person regarding potential exposure to a communicable disease, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting reactions to drugs or problems with products or devices, notifying individuals if a product or device they may be using has been recalled, notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information, notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.
4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person’s agreement, concerning a death we believe has resulted from criminal conduct, regarding criminal conduct at our offices, in response to a warrant, summons, court order, subpoena or similar legal process, to identify/locate a suspect, material witness, fugitive or missing person, in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)
5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
7. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
9. Workers’ Compensation. Our practice may release your IIHI for worker’s compensation and similar programs.

Patient/Guardian Signature: _____ **Date:** ____ / ____ / _____