Chiropractic & Wellness Center of New Haven
59 Elm Street Ste 100 New Haven, CT 06511

Today's Date: ___/___/_____ Haven you ever consulted a chiropractor before? ◯ Yes ◯ No

If so, who did you see?_____

Whom may we thank for referring you? _____

When was your last visit? _____

Personal Information:

First Name: _____ Last Name: _____ Date of Birth: ___/___/_____

Address _____ City _____ State ____ Zip _____

Home Phone: _____ Work Phone _____ Other Phone: _____

Email Address: _____

Your Occupation: _____ Employer: _____

Address _____ City _____ State ____ Zip _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Seperated

Emergency Contact Information:

First Name: _____ Last Name: _____

Address _____ City _____ State ____ Zip _____

Phone Number _____

Insurance Information:

Insurance Provider: _____

Insured's Full Name: _____ Insured's Date of Birth: _____

Polocy ID #: _____ Group #: _____ Policy Holder: ◯ Self ◯ Spouse ◯ Parent

Insured's Employer: _____

Address _____ City _____ State ____ Zip _____

1. The symptoms that have prompted me to seek care today include:

2. And are the result of (darken circle) ◯ Accident/Injury:

◯ Work Related ◯ Auto ◯ Other:_____

◯ A worsening long term problem

◯ An Interest in:

◯ Wellness ◯ Other_____

Patient Name: _____

3. **Onset** (when did you first notice your current symptoms?)

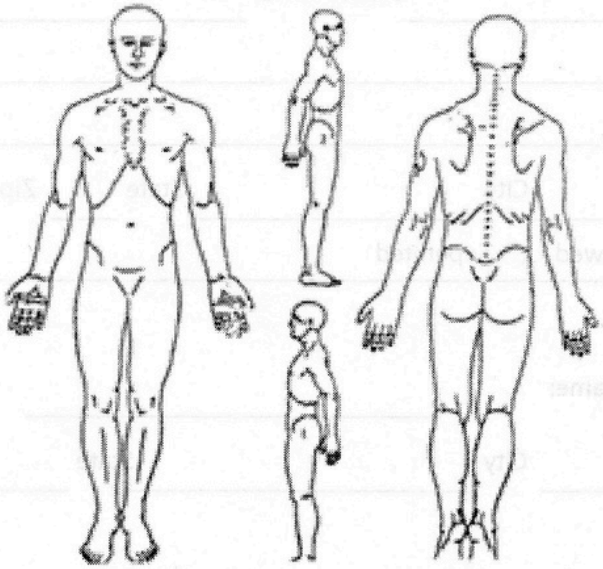
4. Intensity
(How extreme are your current symptoms?) Scale of 1 - 10

5. Duration and Timing
(How did it start and how often do you feel it?)

6. Quality of symptoms (What does it feel like?)

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other

7. Location
(where does it hurt?)
Circle the area(s) on the illustration



8. Radiation
(Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel?)

9. Aggravating or Relieving Factors
(What makes it better or worse, such as time of day, movements, certain activities, etc...)

10. Prior Interventions
(What have you done to reduce the symptoms?)

- ◯ Prescription Medication
- ◯ Surgery
- ◯ Other
- ◯ Over-the-Counter drugs
- ◯ Accupuncture
- ◯ Homeopathic Remedies
- ◯ Chiropractic
- ◯ Physical Therapy
- ◯ Massage

11. What else should the doctor know about your current condition?

12. How does your current condition interfere with your:

Work or Career

Recreational Activities

Household Responsibilities

Personal Relationships

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please check any conditions you've HAD or currently HAVE.

a. Musculoskeletal

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Osteoperosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck Pain
☐	☐	Knee Injuries	☐	☐	Foot/Ankle Pain	☐	☐	Shoulder Problems	☐	☐	Elbow/Wrist Pain
☐	☐	Back Problems	☐	☐	Hip Disorders	☐		None			
☐	☐	TMJ Issues	☐	☐	Poor Posture						

Initials _____

Patient Name: _____

13. Review of Systems (cont)

Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please check any conditions you've HAD or currently HAVE.

b. Neurological

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Dizziness	☐	☐	Pins & Needles
☐	☐	Numbness	☐	☐	Headaches		☐	None			

Initials ☐

c. Cardiovascular

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐	Poor Circulation	☐	☐	Angina
☐	☐	Excessive Bruising	☐	☐	High Cholesterol		☐	None			

Initials ☐

d. Respiratory

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hay Fever
☐	☐	Shortness of Breath	☐	☐	Pneumonia		☐	None			

Initials ☐

e. Digestive

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Anorexia/Bulemia	☐	☐	Ulser	☐	☐	Food Sensitivities	☐	☐	Heart Burn
☐	☐	Constipation	☐	☐	Diarriah		☐	None			

Initials ☐

f. Sensory

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Blurred Vision	☐	☐	Hearing Loss	☐	☐	Loss of Smell	☐	☐	Loss of Taste
☐	☐	Ringing Ears	☐	☐	Chronic Ear Infecetion		☐	None			

Initials ☐

g. Integumentary

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Skin Cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne
☐	☐	Hair Loss	☐	☐	Rash		☐	None			

Initials ☐

h. Endocrine

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Thyroid Issues	☐	☐	Immune Disorders	☐	☐	Hypoglycema	☐	☐	Frequent Infection
☐	☐	Swollen Glands	☐	☐	Low Energy		☐	None			

Initials ☐

i. Genitourinary

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Kidney Stones	☐	☐	Infertility	☐	☐	Bedwetting	☐	☐	Prostate Issues
☐	☐	Erectile Disfunction	☐	☐	PMS Symptoms		☐	None			

Initials ☐

j. Constitutional

HAD	HAVE		HAD	HAVE		HAD	HAVE		HAD	HAVE	
☐	☐	Fainting	☐	☐	Low Libido	☐	☐	Poor Appetite	☐	☐	Fatigue
☐	☐	Weakness	☐	☐	Sudden Weight Change		☐	None			

Initials ☐

Patient Name: _____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

14. **Illnesses** Check the Illnesses you have HAD in the past or HAVE now.

HAD	HAVE	
☐	☐	AIDS
☐	☐	Alcoholism
☐	☐	Allegies
☐	☐	Arteriosclerosis
☐	☐	Arthritis
☐	☐	Cancer
☐	☐	Chicken Pox
☐	☐	Diabetes
☐	☐	Eczema
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Goiter
☐	☐	Gout
☐	☐	Heart Disease
☐	☐	Hepatitis
☐	☐	Malaria
☐	☐	Measles
☐	☐	Multiple Sclerosis
☐	☐	Mumps
☐	☐	Pneumonia
☐	☐	Polio
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	STD
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Typhoid Fever
☐	☐	Ulcer
☐	☐	Other

15. **Operations**: Surgical interventions, which may or may not have included hospitalization.

HAD	HAVE	
☐	☐	Appendix Removal
☐	☐	Bypass Surgery
☐	☐	Cancer
☐	☐	Cosmetic Surgery
☐	☐	Elective Surgery
☐	☐	Eye Surgery
☐	☐	Hysterectomy
☐	☐	Pacemaker
☐	☐	Tonsillectomy
☐	☐	Vasectomy
☐	☐	Other

17.Injuries Have you ever:

- ☐ Had a fractured or broken bone
- ☐ Had a spine or nerve disorder
- ☐ Been injured by an accident
- ☐ Been knocked unconscious
- ☐ Used a crutch or other support
- ☐ Used neck or back bracing
- ☐ Had a body peircing

16. Treatments Check the ones you have received in the PAST or are CURRENTLY receiving

PAST	PRESENT	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth Control Pills
☐	☐	Blood Transfusions
☐	☐	Chemotherapy
☐	☐	Chiropractic Care
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone Replacements
☐	☐	Massage Therapy
☐	☐	Physical Therapy
☐	☐	Nutritional Supplements
☐	☐	Medications

18. Family HIstory

Some health issues are hereditary. Tell us about the health of your immediate family members.

RELATIVE	AGE	STATE OF HEALTH	ILNESSES	AGE AT DEATH	CAUSE OF DEATH
Mother		◯ Good ◯ Poor			◯ Natural ◯ Illness
Father		◯ Good ◯ Poor			◯ Natural ◯ Illness
Sister		◯ Good ◯ Poor			◯ Natural ◯ Illness
Sister		◯ Good ◯ Poor			◯ Natural ◯ Illness
Brother		◯ Good ◯ Poor			◯ Natural ◯ Illness
Brother		◯ Good ◯ Poor			◯ Natural ◯ Illness

19. Are there any other hereditary health issues that we should know about?

20. Social Historry

Patient Name:

Tell us about your health habits and stress levels.

Alcohol Use	◯ Daily	◯ Weekly	How Much?	Hobbies		
Coffee Use	◯ Daily	◯ Weekly	How Much?	Prayer or Meditation?	◯ Yes	◯ No
Tobacco Use	◯ Daily	◯ Weekly	How Much?	Job Pressure/Stress	◯ Yes	◯ No
Exercising	◯ Daily	◯ Weekly	How Much?	Financial Pressure?	◯ Yes	◯ No
Pain Relievers	◯ Daily	◯ Weekly	How Much?	Vaccinated?	◯ Yes	◯ No
Soft Drinks	◯ Daily	◯ Weekly	How Much?	Mercury Fillings?	◯ Yes	◯ No
Water Intake	◯ Daily	◯ Weekly	How Much?	Recreational Drugs?	◯ Yes	◯ No

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	None	Mildly	Moderately	Severly		None	Mildly	Moderately	Severly
Sitting	◯	◯	◯	◯	Grocery Shopping	◯	◯	◯	◯
Rising out of Chair	◯	◯	◯	◯	Household Chores	◯	◯	◯	◯
Standing	◯	◯	◯	◯	Lifting objects	◯	◯	◯	◯
Walking	◯	◯	◯	◯	Reaching overhead	◯	◯	◯	◯
Lying Down	◯	◯	◯	◯	Showering/Bathing	◯	◯	◯	◯
Bending Over	◯	◯	◯	◯	Getting dressed	◯	◯	◯	◯
Climbing Stairs	◯	◯	◯	◯	Love life	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯	Getting to sleep	◯	◯	◯	◯
Getting in/out of Car	◯	◯	◯	◯	Concetrating	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯	Exercising	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯	Yard Work	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯	Staying asleep	◯	◯	◯	◯

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____

24. What is the approximate age of your mattress & pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits ◯ Skip Breakfast ◯ Two Meals/day ◯ Three meals/day ◯ Snacking between meals

27. What would be the most significant thing that you could do to improve your health?

28. In addition to the main reason for your visit today, what additional health goals do you have?

Patient Name: _____

Acknowledgements

Initials

_____ I instruct the chiropractor to deliver the care that, in her or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation.. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I grant permissions to be called to confirm or reschedule an appointment.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

_____
Signature

Date _____

_____
Print Name

Chiropractic & Wellness Center

of

New Haven

Informed Consent for Chiropractic Care

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo Chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nerve system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well- being, not merely the absence of disease or infirmity.**

One disturbance to the nerve system is called a **vertebral subluxation.** This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nerve system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by hand held instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-Chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of Chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept Chiropractic care on this basis.

_____ _____ _____

Print name Date Signature

Consent to evaluate and adjust a minor child:

I,_____, being the parent or legal guardian of _____, have read and fully understand the above Informed Consent and hereby grant permission for my child to receive Chiropractic care.

Pregnancy release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:_____ Signature_____ Date_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

We're glad you're here and look forward to supporting your health and wellness.

To help us provide the best care and keep our schedule running smoothly, please review and acknowledge the following policies:

1. Payment Policy
   - Payment in full is due at the front desk on the day of service and at the end of your appointment.
   - We accept - cash, credit/debit cards, HSA/FSA cards
2. Punctuality
   - We allow a 15-minute grace period for late arrivals, after such you will be seen as time allows.
   - Please plan accordingly to ensure you receive your full appointment time.
3. Cancellation Policy
   - If you need to cancel or reschedule an appointment, we require a minimum of 24 hours' notice.
   - Appointments cancelled with less than 24 hours' notice, or missed appointments, will incur a $55 cancellation fee.

I have read and understand the above policies. I agree to abide by the payment and cancellation terms stated.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

CHIROPRACTIC & WELLNESS CENTER OF NEW HAVEN