Dr. Lori Sprague
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Please complete and return to our patient facilitator at the front desk

New Patient Information

Title you prefer: Mr. Mrs. Miss Ms. Dr. Pastor Marital Status: Married Single Divorced Widowed

Patient Name: _____
Legal First Middle Last Nickname

Address: _____
Street City State Zip

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ E-Mail: _____

Which phone number do you prefer we use to contact you? Home Cell Work

Sex: Male Female Social Security #: _____-_____-_____ Birth date: _____/_____/_____ Age: _____

Employer: _____ Occupation: _____

Who may we thank for referring you? _____

Spouse Information

Spouse's Name: _____
Legal First Middle Last Nickname

Social Security #: _____-_____-_____ Birth Date: _____/_____/_____ Age: _____

Employer: _____ Occupation: _____

Cell Phone (_____) _____ Work Phone (_____) _____

Parent Information (If patient is 18 or under)

Parent Name: _____
Legal First Middle Last Nickname

Address: _____
Street City State Zip

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ E-Mail: _____

Which phone number do you prefer we use to contact you? Home Cell Work

Sex: Male Female Social Security #: _____-_____-_____ Birth date: _____/_____/_____ Age: _____

Employer: _____ Occupation: _____

Closest Living Relative (Someone not living with you, in case of emergency.)

Name: _____ Relationship: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Other Information

Have you ever been diagnosed with cancer? _____ If yes, when? _____

Auto Accident Information

Was a police report filed? No___ Yes___ **Were there other people in the car?** No___ Yes____ How Many? _____

Whose fault was the accident? Yours ____ The driver of other car ____ The driver of car you were in ____

Do you have Med-Pay? Yes ____ No ____ **Amount?** _____

Your Med-Pay Information

Company _____
Address _____
City/St/Zip _____
Policy # _____
Claim # _____
Phone #: _____
Adjuster _____

Other Party's Insurance Information

Company_____
Address _____
City/St/Zip _____
Policy # _____
Claim # _____
Phone # _____
Adjuster _____

Attorney Information

Name:_____Phone:_____

Address: _____

Date and time of the accident? _____/_____/_____ ___:___ **AM/PM** **Number of vehicles involved:** _____

Was your vehicle totaled? ___ No ____ Yes, estimated damage $ _____

Street or intersection name: _____ **What direction were you traveling?** _____

City and State of accident: _____

Type of impact: _____ my vehicle was rear-ended
_____ my vehicle was hit on driver side
_____ my vehicle was hit on passenger side
_____ my vehicle was hit head on
_____ my vehicle rear-ended another vehicle
_____ my vehicle hit another vehicle on driver side
_____ my vehicle hit another vehicle on passenger side
_____ my vehicle hit another vehicle head on

Did your vehicle hit anything after the accident? ___ no If yes, please describe_____

Where were you sitting in the vehicle during the accident? ___ Driver ___ Front Passenger ___ Back Left Passenger ___ Back Right Passenger ___ Other _____

Mark one of the following: _____ I was unaware the accident was coming. _____ I was aware of the impending accident and relaxed. _____ I was aware of the impending accident and braced myself.

What type of vehicle were you in? _____ **What type of vehicle impacted yours?** _____

Was your vehicle? ____ slowing down ____ stopped _____ gaining speed _____ moving at a steady speed

Was the other vehicle? ____ slowing down ____ stopped _____ gaining speed _____ moving at a steady speed

At time of impact, how fast were you going? _____ **How fast was the other vehicle going?** _____

During and after the crash what happened to your vehicle? (Check all that apply) ___ kept going straight ___ spun around ___ kept going straight hitting a car in front ___ spun around and hit a stationary object ___ was hit by another vehicle ___ hit a stationary object ____ other _____

Patient Name: _____ **DOB:** ____/____/____

Did you lose consciousness during the accident? ___ No ___ Yes If yes, how long were you unconscious? _____

How was your head positioned during the accident? _____

How was your torso positioned during the accident? _____

How were your hands positioned during the accident? _____

Did any area of your body hit anything in or out of the vehicle during the accident? ___ No ___ Yes **If yes, please mark which area and where in or out of the vehicle you hit:** __ head _____ __ face _____
__ neck _____ __ chest_____ __ arm L/R _____ __ wrist L/R_____ __ hip L/R _____ ____ knee L/R _____
____ foot L/R_____

What kind of headrest was in your vehicle? _____ movable fixed headrest _____ non-movable fixed headrest
_____no headrest

Where was the headrest positioned on your head? ____ top-back of head ____ middle height-back of head
____ lower portion-back of head _____ level-back of neck _____ level-shoulder blades

Was your seatbelt on during the accident? ___ No ___ Yes If yes what type of seatbelt: _____ shoulder/lap
_____ lap _____ baby car seat _____ booster seat _____ cannot remember

Did you slide out of your seatbelt? ____ No _____ Yes, completely ____ Yes, partially Other:_____

What was damaged in your vehicle? (Check all that apply)
___ windshield ___ steering wheel ___ dashboard ___ seat frame ___ side window
___ rear window ___ mirror ___ knee bolster ___ rear bumper ___ front bumper
___ trunk ___ front left door ___ front right door ___ back left door ___ back right door
___ completely totaled ___ other _____

Which doors would not open as a result of the accident: ___ front left ___ front right ___ rear left ___ rear right
____ trunk ____ tailgate

Did you go to the hospital? ____ No ____Yes **if yes, please continue answering questions on this page.**

How did get to the hospital? ___ ambulance ___ helicopter ___ police car ___ friend drove ___ drove self
___ walked

What was the name of the hospital? _____ **Were you hospitalized over night?** ___ Yes ___ No

What you were prescribed at the hospital? ____ pain meds ____ muscle relaxor ____ neck brace ____ back brace

Did you receive any stitches for any cuts at the hospital? _____

Were x-rays taken at the hospital? If yes, which area was x-rayed? _____

Was an MRI performed? If yes, on which area was the MRI? _____

Did you receive any special imaging? If yes, on which area was the special imaging? _____

May we request x-ray, MRI, special imaging reports, if needed? ____ Yes ____ No

Patient Name: _____ **DOB:** ____/____/____

Please fill in complaint area for complaints you currently have resulting from the accident dated _____/_____/_____.

Complaint Area #1: _____

How often do you experience your symptom? □ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain? □ Sharp □ Numb □ Dull □ Tingly □ Diffuse □Shooting □ Achy □ Shooting with motion □ Burning
□ Stabbing with motion □ Sharp with motion □ Stiff □ Electric like with motion
□ Other: _____

How is your symptom changing with time? □ Worse □ Staying the Same □ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

How much has your symptom interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has your symptom interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Complaint Area #2: _____

How often do you experience your symptom? □ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain? □ Sharp □ Numb □ Dull □ Tingly □ Diffuse □Shooting □ Achy □ Shooting with motion □ Burning □ Stabbing with motion □ Sharp with motion □ Stiff □ Electric like with motion
□ Other: _____

How is your symptom changing with time? □ Worse □ Staying the Same □ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

How much has your symptom interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has your symptom interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Patient Name: _____ **DOB:** ____/____/____

Complaint Area #3: _____

How often do you experience your symptom? □ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain? □ Sharp □ Numb □ Dull □ Tingly □ Diffuse □Shooting □ Achy □ Shooting with motion □ Burning □ Stabbing with motion □ Sharp with motion □ Stiff □ Electric like with motion
□ Other: _____

How is your symptom changing with time? □ Worse □ Staying the Same □ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

How much has your symptom interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has your symptom interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Complaint Area #4: _____

How often do you experience your symptom? □ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain? □ Sharp □ Numb □ Dull □ Tingly □ Diffuse □Shooting □ Achy □ Shooting with motion □ Burning □ Stabbing with motion □ Sharp with motion □ Stiff □ Electric like with motion
□ Other: _____

How is your symptom changing with time? □ Worse □ Staying the Same □ Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

How much has your symptom interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has your symptom interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Patient Name: _____ **DOB:** ____/____/____

How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Place a check if any of your immediate family members have the following:
□ RA □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

List all prescription and over-the counter medications you are currently taking: _____
_____

List all vitamins and other supplements you are currently taking: _____
_____

What activities do you do at work? (check all that apply)
___ Travel a lot ___ Read a lot
___ Sit ___ Most of the day ___ Half of the day ___ A little of the day
___ Stand ___ Most of the day ___ Half of the day ___ A little of the day
___ Computer Work ___ Most of the day ___ Half of the day ___ A little of the day
___ Use the Phone ___ Most of the day ___ Half of the day ___ A little of the day

What activities do you do outside of work? (check all that apply) ____ Housework/laundry ____ Fixing/building things _____ Reading _____ Watching TV _____ Exercising, describe _____
_____ Take care of children _____Other _____

Have you seen a Chiropractor before? ____ No ____ Yes If yes, how long ago? _____

What were the results? ___ Great ___ Good ____ Fair ____ Mixed ____ Poor ___ Other:_____

List all hospitalization, surgical procedures and significant past traumas: _____
_____

Is there anything else the doctor needs to know about you or your health? _____

Are there any diseases that you have been diagnosed with by your medical doctor (please list)?_____
_____

I verify these statements are true to the best of my knowledge:

Signature_____ **Date:** _____
Patient or Parent/Guardian

REVISED LOW BACK OSWESTRY INDEX

Name:_____ **Date:**_____ **File #:**_____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 - Pain Intensity
- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderately increasing
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)
- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting
- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 - Walking
- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 - Sitting
- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6 - Standing
- I can stand as long as I want without pain.
- I have some pain standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping
- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than ¼.
- Because of pain, my normal night's sleep is reduced by less than ½.
- Because of pain, my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

SECTION 8 - Social Life
- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- Pain has restricted my social life and I do not go much.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

SECTION 9 - Traveling
- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternate forms of travel.
- Pain prevents all forms of travel except done lying down.
- Pain restricts all forms of travel.

SECTION 10 - Changing Degrees of Pain
- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but slowly improves.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

NECK DISABILITY INDEX

Name:_____ **Date:**_____ **File #:**_____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

SECTION 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 - Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can not do any work at all.

SECTION 8 - Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

SECTION 9 - Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

Symptoms **Patient Name** _____ **DOB** ___/___/___

Please mark complaint area for complaints you currently have resulting from the accident on _____/____/_____.

Orthopedic & Musculoskeletal Symptoms

___ "Clunk" Sound with Neck Movements
___ Neck Pain
___ Upper Back Pain
___ Low Back Pain
___ Shoulder Pain ___ Left ___ Right
___ Upper Arm Pain ___ Left ___ Right
___ Elbow Pain ___ Left ___ Right
___ Forearm Pain ___ Left ___ Right
___ Wrist Pain ___ Left ___ Right
___ Hand Pain ___ Left ___ Right
___ Hip Pain ___ Left ___ Right
___ Upper Leg Pain ___ Left ___ Right
___ Knee Pain ___ Left ___ Right
___ Lower Leg Pain ___ Left ___ Right
___ Ankle Pain ___ Left ___ Right
___ Foot Pain ___ Left ___ Right
___ Jaw Pain
___ Clicking in Jaw
___ Pain when Chewing
___ Face Pain
___ Chest Pain
___ Stomach Pain
___ Bruise/Contusion to _____
___ Abrasion /Scrape to _____
___ Other Symptom _____
___ Other Symptom _____

Neurological Symptoms

___ Numb/Tingling Arm / Hand L R
___ Numb/Tingling Leg / Foot L R
___ Weakness Arm / Hand L R
___ Weakness Leg / Foot L R

Symptoms Associated with Injuries

___ Range of Motion Problems
___ Headaches
___ Muscle Spasms
___ Dizziness
___ Visual Disturbances
___ Sleep Disruption
___ Radiating Pain
___ Anxiety
___ Depression
___ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

___ Wanting to be Alone
___ Sleepiness
___ Nausea/Vomiting
___ Difficulty Concentrating
___ Day Dreaming/Staring Mindless Staring
___ Mood Swings
___ Agitation
___ Sadness or tearful
___ Blurry Vision
___ Double Vision
___ Disoriented
___ Confused
___ Difficulty Speaking
___ Feelings of Isolation from Others
___ Attention Problems
___ Appetite Changes
___ Pupils Different Sizes
___ Room Spins/Woozy Feeling
___ Balance Problems
___ Difficulty Walking
___ Difficulty Focusing/Easily Distracted
___ Very Tired
___ Dozing During the Day
___ Personality Change
___ Can't Remember Numbers
___ Reading Problems
___ Writing Problems
___ Difficulty with Adding/Subtracting
___ Poor Attention
___ Difficulty Learning New Things
___ Difficulty Understanding
___ Difficulty Remembering Things
___ Re-reading things to understand it
___ Anger
___ Difficulty Making Decisions
___ Change in Sexual Functioning
___ Reduced Confidence
___ Helplessness
___ Apathy (Don't Care)
___ Irritable
___ Change in Sense of Taste or Smell
___ Flashbacks to Accident
___ Impatience
___ Frustration
___ Hearing Problems
___ Difficulty Planning or Organizing

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Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation. However, we may use other procedures to help your body hold the adjustments.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____/_____/_____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance 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 an x-ray can be hazardous to an unborn child. Date of last menstrual period: _____/_____/_____

_____ _____/_____/_____
(Signature) (Date)

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature: _____ Print Name: _____Date_____/_____/_____