APPLICATION FOR CARE AT MACOMB TOWNSHIP CHIROPRACTIC

Today's Date: _____ *Who may we thank for referring you to this office* _____

PATIENT DEMOGRAPHICS

Full Name: _____ Nickname: _____

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

Address: _____City: _____State: _____ Zip: _____

E-mail Address: _____

Home Phone: _____ Mobile Phone:_____

Marital Status: ☐ Single ☐ Married Spouse's Name _____

Emergency contact:_____Phone #:_____

Do you have Insurance: ☐ Yes ☐ No Social Security # _____

Employer: _____ Occupation: _____

Accident History:

Have you been injured in an automobile accident? ☐ Yes ☐ No

Accidents within the past year: (Date and Describe) _____

Accidents Over a year ago: (Date and Describe) _____

Hospitalizations related to current complaints: (Date and Describe) _____

_____

***CHECK* ANY CONDITION(S) YOU HAVE NOW or HAVE HAD IN THE PAST:**

☐ **STROKE** ☐ **CANCER** ☐ **HIGH BLOOD PRESSURE** ☐ **SPINAL SURGERY** ☐ **SEIZURES** ☐ **BLOOD CLOTS** ☐ **OSTEOPOROSIS**

List all past surgical operations and the years they were performed related to your current complaints:

_____

_____

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

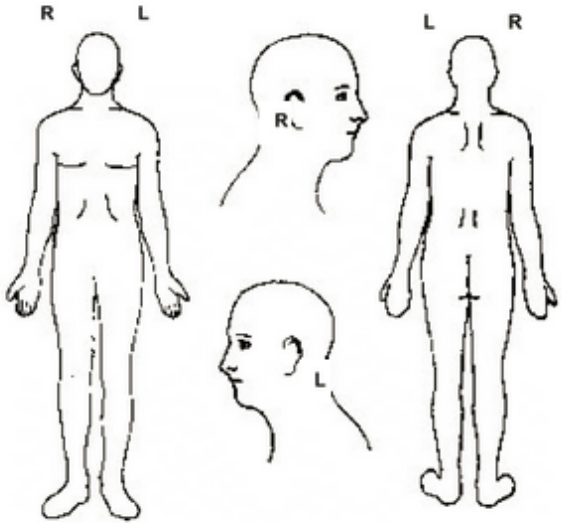
_____

_____

Women Only: Are you pregnant? **Y/N** Due Date: _____ Last Menstrual Period: _____

Name: _____ Date: _____

Mark an **"X"** on the body where you have pain, numbness, tingling or other symptoms.



Please Circle The Number That Best Describes Your Pain

HEADACHE										
0	1	2	3	4	5	6	7	8	9	10
NONE			LITTLE			MEDIUM				SEVERE
NECK										
0	1	2	3	4	5	6	7	8	9	10
NONE			LITTLE			MEDIUM				SEVERE
SHOULDER / ARM / HAND										
0	1	2	3	4	5	6	7	8	9	10
NONE			LITTLE			MEDIUM				SEVERE
MID/UPPER BACK										
0	1	2	3	4	5	6	7	8	9	10
NONE			LITTLE			MEDIUM				SEVERE
LOW BACK										
0	1	2	3	4	5	6	7	8	9	10
NONE			LITTLE			MEDIUM				SEVERE
HIP / LEG PAIN / FOOT										
0	1	2	3	4	5	6	7	8	9	10
NONE			LITTLE			MEDIUM				SEVERE
Not Listed (Write Down) -										
0	1	2	3	4	5	6	7	8	9	10

What is your main health concern? 1. _____

When did it begin? ☐ Days Ago ☐ Weeks Ago ☐ Months Ago ☐ Years Ago ☐ Decades Ago or Date:_____

How did it happen? ☐ Auto Accident ☐ Job Related ☐ Fall ☐ At Home ☐ Sport Injury ☐ Unknown

Other health concerns? 2._____ 3._____ 4._____ 5._____

MARK AN "X" ON WHAT ACTIVITIES THAT ARE LIMITED BY YOUR HEALTH COMPLAINTS:

☐ Work ☐ House Work ☐ Yard Work ☐ Recreation ☐ Activities ☐ Sports ☐ Family / Kids ☐ School
☐ Sleeping ☐ Driving ☐ Bathing/Showering ☐ Walking ☐ Standing ☐ Bending ☐ Lifting ☐ Twisting

WRITE DOWN SPECIFICALLY WHAT ACTIVITIES ARE LIMITED BY YOUR HEALTH COMPLAINTS:

Example: Standing/sitting at work, vacuuming the carpet, swinging a golf club, riding a motorcycle, working out…

1. _____
2. _____
3. _____

OFFICE USE ONLY

Health Concerns	Severity (0 -10)	When did it start?	Had it before?	Start with Injury?	Constant/ Intermit

1. _____
2. _____
3. _____
4. _____
5. _____

Name: _____ Date: _____

HEALTH HISTORY PROFILE: Please check any of the conditions that **YOU** or your family **HAVE NOW** or have **HAD** in the past.

CONDITION	YOU	SPOUSE	CHILDREN	MOTHER	FATHER	SIBLING
Headache / Migraines						
Neck Pain						
Jaw Pain / TMJ						
Shoulder Pain						
Upper Back Pain						
Mid Back Pain						
Low Back Pain						
Hip Pain						
Poor Posture						
Scoliosis						
Disc Bulge/ Herniation						
Disc Degeneration / Arthritis						
Sciatica						
Numb / Tingling arms, hands,						
Numb / Tingling legs, feet, toes						
Spinal Surgery						
Muscle Weakness						
Seizures						
Foot / Knee Problems						
Allergies / Sinus Problems						
Swollen/Painful Joints						
Dizziness /Vertigo/Balance Issues						
Ringing in Ears / Tinnitus						
Vision Problems						
ADD/ADHD /Concentration						
Prostate Problems						
Sexual Disfunction						
Digestive Problems						
Heartburn						
Menstrual Problems						
Bed Wetting						
Trouble Sleeping						
Heart Problems / Palpitations						
Asthma / Lung Problems						
Urinary / Kidney Trouble						
Anxiety / Depression / Moody						
Thyroid						
Diabetes / Blood Sugar						

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 risks 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 Macomb Township Chiropractic 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.

_____ _____
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.*

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.

_____ _____
Patient or Authorized Person's Signature Date

REGARDING: Payments/Insurance

I hereby authorize payment to be made directly to Macomb Township Chiropractic, 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 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 Macomb Township Chiropractic for any and all services I receive at this office.

_____ _____
Patient or Authorized Person's Signature Date

MACOMB TOWNSHIP CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY

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. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. 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 areas 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 imminent 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 from 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.

I have received a copy of Macomb Township Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's 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 a 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.

_____ _____

Signature Date