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

APPLICATION FOR CARE AT Hamilton Family Chiropractic Center

Today's Date: __________________ HRN: ____________________

PATIENT DEMOGRAPHICS

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

Address: ____ City: ________________________________ State: _____ Zip: ___________

E-mail Address: ___________________________________ Home Phone: _______________________Mobile Phone: _______________

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _______________________________

Social Security #: __________________________________ Driver's License #: ____

Employer: _______________________________________ Occupation: ____

Spouse's Name ____Spouse's Number ____

Number of children: ____ Ages:____

Name of Emergency Contact: _________________________ Phone Number__________________ Relationship:____________________

Insurance Name:____________________________________ Policy Card #_______________________________

Secondary:____ Policy Card #_______________________________

Please Present insurance card(s) to the front desk, so we can copy them.
Permanent Resident/ Seasonal

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: ____
Secondarily: _________________________ Third: ____________________________ Fourth: __________________________________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate you're 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
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem(s) begin? ____________________ 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

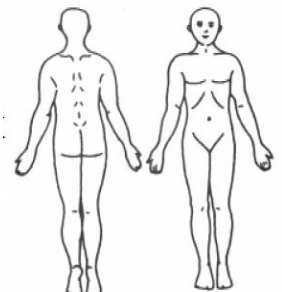
How did the injury happen?____________

Condition(s) ever 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**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling



What relieves your symptoms? ____________________________

What makes them feel worse? _________________________________

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
___________________________________:	_______________________________________	_______________________________________
___________________________________:	_______________________________________	_______________________________________

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

The majority of my patients have experienced dozens of impacts that can cause Vertebral Subluxation. By the time a child can walk they would have fallen 1,000 times. Identify all injuries that your spine has gone through throughout your entire life. This includes: Auto accidents, slips and falls, twists or strains at work, sports or recreational injuries, or injuries at home.

____

____

____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes** how many times? _________ When was the last episode? ______________________ How did the injury happen?____________

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: ______________________________, and who provided it: __________________________ **How long ago? _______**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. ____
Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

____

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

___ Any Headache	___ Pregnant (Now)	___ Dizziness/ Fainting	___ Prostate Problems	___ Ulcers/Colitis	___IBS
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/ Sexual Dysfunction	___ Heartburn	___HIV/Aids
___ Jaw Pain, TMJ	___ Convulsions/ Epilepsy	___ Shingles	___ Digestive Problems	___ Heart Problem/ Heart Attack/ Stroke	___ Fracture
___ Shoulder Pain	___ Tremors	___ Ringing in Ears	___ Double Vision	___ Colon Trouble	___ High/Low Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Hearing Loss	___ Blurred Vision	___ Diarrhea/ Constipation	___Tuberculosis
___ Mid Back Pain	___ Venereal Disease	___ Depression	___ Menopausal Problems	___ Asthma	___ Psychiatric Problems
___ Low Back Pain	___ Foot or Knee Problems	___ Irritable	___ Menstrual Problem	___ Difficulty Breathing	___ Tumors
___ Hip Pain	___ Sinus/Drainage Problem	___ Mood Changes	___ PMS	___ Lung Problems	___Bronchitis
___ Back Curvature	___ Swollen/Painful Joints	___ Eating Disorder	___ Bed Wetting	___ Kidney Trouble	___ Diabetes
___ Scoliosis	___ Skin Problems	___ Trouble/loss of Sleeping	___ Learning Disability	___ Gall Bladder Trouble	___ Any Arthritis
___ Numb/Tingling arms, hands, fingers	___ ADD/ADHD	___ Fevers	___ Liver Trouble	___Cerebral Vascular	___ Cancer
___ Numb/Tingling legs, feet, toes	___ Allergies	___ Thyroid	___ Hepatitis (A,B,C)	___ Anemia	___ Broken Bone

For Women

Are you nursing? ___Yes ___No Are you taking birth control? ___Yes ___No
Do you experience painful periods? ___Yes ___No Do you have irregular cycles? ___Yes ___No
Do you have breast implants? ___Yes ___No

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

SOCIAL HISTORY

Medications I Now Take:

___Nerve Pills ___Pain Killers (including Aspirin) ___Muscle Relaxers ___Blood Pressure Medicine
___Insulin ___Stimulants ___Blood Thinners ___Tranquilizers
___Other____

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Coffee: How many cups/day _______________
4. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
5. Do you wear: ___Heels ___Sole lifts ___Inner Soles Arch Soles
6. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following

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 Hamilton Family Chiropractic Center, 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 Hamilton Family Chiropractic Center for any and all services I receive at this office.

_______________________________________ ______ - ______ - ______
Patient or Authorized Person's Signature **Date Completed**

_______________________________________ _______ - _______ - ______
Doctor's Signature **Date Form Reviewed**

Patient's Name: ____________________________ **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 Hamilton Family Chiropractic Center 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 persons Signature Date

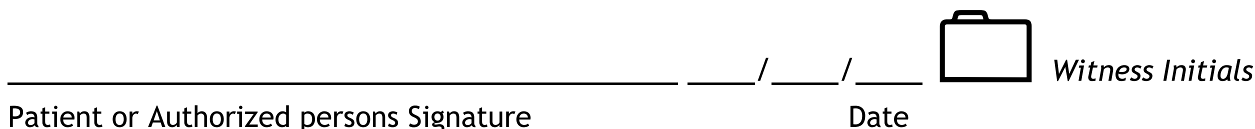
REGARDING: X-rays/Imaging Studies

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 mostly 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 persons Signature Date

JDD, DC 5/2011

Hamilton Family Chiropractic Center 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. 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 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 up coming 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 Dr. Colleen Conger, D.C. at (408) 839-0584 if she is unavailable, you may make an appointment with Jessica to see the doctor 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***

Hamilton Family Chiropractic Center's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Hamilton Family Chiropractic Center'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 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.

____ _____________
Patient's Name DOB

____ _____________
Patient signature Date

____ _____________
Witness Date

Hamilton Family Chiropractic Center

Michael D Brass D.C.
Colleen Conger-Brass D.C.

What are your life goals and where do you see yourself in the next 10 to 20 years?

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

____________________________ ________________

Signature

Date