Whom may we thank for referring you to this office → _____

Application for care at Hamilton Family Chiropractic Center Today's Date _____

Name _____ Birthday _____ Age _____ ☐ Male ☐ Female
Address _____ City _____
State _____ Zip _____ Email Adress _____
Home Phone _____ Mobile Phone _____

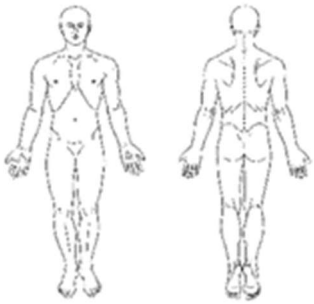
Marital Status ☐ Single ☐ Married
Spouse Name _____ Spouse Phone Number _____
# of Children ___ Ages _____
Name of Emergency Contact _____ Phone Number of Emergency Contact _____
Relationship to Emergency Contact _____
Driver's License _____ Social Security _____ Employer _____ Occupation _____
Insurance Provider _____ Insurance Policy #_____
Policy Start Date _____
Please present insurance card to the front desk so we may validate coverage of your policy.

History of Complaint
Please identify the conditions that brought you into the office today
Primarily_____
Secondarily _____ Third _____ Fourth _____

On a scale of 1 (Worst) to 10 (No Pain) rate you're above complaints by circling the number:
Primary complaint is 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is 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 = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling



What relieves your symptoms? _____
What makes your symptoms feel worse? _____

List of Restricted Activity	Current Activity Level	Usual Activity Level
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your problem the result of ANY type of accident? ☐ 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 _____ 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 your body _____

If you have ever had any of the following conditions please indicate with a P for Past, C for Currently have, and leave it blank for Never

__ Migraine Headaches	__ Frequent Colds/Flu	__ Dizziness	__ Menopausal Problems	__ Gall Bladder Problems	__ Rheumatoid Arthritis
__ Headaches	__ Epilepsy	__ Ringing in the ears	__ Bedwetting	__ Anemia	__ Hashimoto's Disease
__ Neck Pain	__ Chest Pain	__ Hearing Loss	__ Liver Problems	__ IBS	__ Fibromyalgia
__ TMJ Pain	__ Venereal Disease	__ Depression	__ Heartburn/Acid Reflux/Stomach Ulcer	__ HIV	__ Gouty Arthritis
__ Shoulder Pain	__ Foot or Knee Problems	__ Difficulty Sleeping	__ Heart Problems	__ Fracture	__Crohn's Disease
__ Upper Back Pain	__ Sinus Infections	__ Eating Disorder	__ Heart Attacks	__ High/Low blood pressure	__ Lupis Erythematosus
__ Mid Back Pain	__ Painful Joints	__ Thyroid Problems	__ Strokes	__ Tuberculosis	__ ADD/ADHD
__ Low Back Pain	__ Skin Problems	__ Prostate Problems	__ Hemorrhoids	__ Psychiatric Problems	__ Shingles
__ Hip Pain	__ Autism	__ Sexual Disfunction	__ Diarrhea/Constipation	__ Bronchitis	__ Menstrual Problems
__ Numbness/Tingling legs, feet, toes	__ Allergies	__ Digestive Problems	__ Asthma	__ Diabetes	__ Kidney Problems
__ Numbness/Tingling arms, hands, fingers	__ Joint Replacement	__ Blurred Vision	__ Pneumonia	__ Cancer	__ Low Libido

For Women

Do you experience painful periods? ☐ Yes ☐ No
Do you experience heavy bleeding? ☐ Yes ☐ No
Do you have irregular cycles? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No
Are you taking birth control? ☐ 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 that may be contributing to your present problem

Social History

Medications I Now Take

__ Nerve Pills __ Pain Killers __ Blood Pressure Medicine __ Insulin __ Stimulants __ Blood Thinners __ Tranquillizers

Others_____

Smoking ☐ Cigars ☐ Pipes ☐ Cigarettes How Often ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Alcoholic Beverages How Often ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Coffee How many cups per day _____

Recreational Drug use How Often ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Do you wear ☐ Orthotics ☐ Heel Lifts ☐ Sole Lifts ☐ Arch Lifts

I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this does not in anyway 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

_____

Print 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.

_____ Date: ___/ ___/_____

Patient or Authorized Person's Signature

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → please read carefully, and check the boxes, including 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.

_____ _____

Signature Date

CMC, DC 2/2024

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. 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 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 even this practice is sold, the new owners would have access to your PHI.

Your Rights:

1. To received 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
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 therefor 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 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

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.

_____ _____

Signature Date

CMC, DC 2/2024

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. _____

9. _____

10. _____

_____ _____

Signature Date