SHERWOOD CHIROPRACTIC PATIENT HEALTH ASSESSMENT

Patient Name: ______________________ Today's Date: ___/___/___ File #: ______________

Patient Address: ______________________ Patient DOB: ___/___/___ Patient SS #: ______________

City: ____________ State: _____ Zip: ______ Home Phone #: ______________ Patient Preferred 1st Name: __________

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed E-mail Address: ______________ Patient Sex: ☐ Male ☐ Female

Patient Employer: ______________________ Patient Occupation: ______________ Referred By: ______________

Patient Employer Address: ______________________ Work Phone #: ______________ # Years Patient Employed: __________

City: ____________ State: _____ Zip: ______ Patient Primary Dr.: ______________ Spouse/Partner Name: __________

Insured Name: ______________________ Insured DOB: ___/___/___ Insured SS #: ______________

Insured Employer: ______________________ Insured Relation to Patient:: __________ # Years Insured Employed: __________

Insurance Company: ______________________ Member #: ______________ Group #: ______________

PLEASE PRESENT ALL INSURANCE CARDS TO THE FRONT DESK AFTER COMPLETING THESE FORMS

COMPLAINT HISTORY:

1. Describe your current complaint(s): 1.) ______________________
   2.) ______________________
   3.) ______________________

2. How long have you had this episode of symptoms? __________ Date of Onset: ___/___/___ Time of day: __________ AM/PM

3. How many days have you experienced symptoms prior to seeking care here? ☐ Less than eight days ☐ More than eight days

4. The number of previous episodes of the current complaint you have experienced in your lifetime? **Think carefully, this is very important!**

   ☐ 0-3 Previous Episodes ☐ 4-7 Previous Episodes ☐ 8 or more Previous Episodes

5. Describe the pain:

   ☐ Dull ☐ Ache ☐ Sharp ☐ Stiffness ☐ Spasm ☐ Soreness ☐ Boring
   ☐ Shooting ☐ Burning ☐ Throbbing ☐ Weakness ☐ Numbness ☐ Tingling ☐ Stabbing

6. Rate the intensity of the pain: **Circle the appropriate number**

   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Low Pain — Moderate Pain — Intense Pain — Emergency

7. How often is the pain and/or symptom(s) present?

   ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

8. Time of the day when your problem is the worst? __________ AM/PM. Time of the day when your condition is the best? __________ AM/PM

9. Since your problem began is the pain **or** dysfunction:

   ☐ Getting worse ☐ Getting Better ☐ Staying the same

10. How did your problem begin?

    ☐ Gradual ☐ Sudden ☐ No Specific Reason ☐ Auto Accident ☐ Work Accident

    Explain what triggered your problem: ______________________

11. What makes your problem better?

    ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐ Certain Position, describe: __________
    ☐ Massage ☐ Ice ☐ Heat ☐ Exercise ☐ Inactivity ☐ Lying down

12. What makes your problem worse?

    ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐ Certain Position, describe: __________
    ☐ Massage ☐ Ice ☐ Heat ☐ Exercise ☐ Inactivity ☐ Lying down

13. Were you previously treated for an earlier occurrence of this same condition? ☐ Yes ☐ No

    If yes, by whom? ☐ MD/DO ☐ Chiropractor ☐ Phys. Therapy ☐ Other: __________

    Provider's name and location: ______________________ Were X-rays taken? ☐ Yes ☐ No

    Approximate dates, type and results of treatment: ______________________

SHERWOOD CHIROPRACTIC PATIENT HEALTH ASSESSMENT

14. List all prescription & over-the-counter medications with their respective dosages that you are currently taking:

____

15. List all vitamins, mineral & herbal supplements with their respective dosages that you are currently taking:

____

16. Exercise: ❑ No exercise ❑ 1-2 times a week ❑ 3-4 times a week ❑ 5-7 times a week Type Exercise: ____________

17. Stress Level: ❑ Minimal stress ❑ Moderate stress ❑ Intense stress Does stress affect your current condition? ❑ Yes ❑ No

18. Is your problem affecting your ability to work or perform normal daily activities?

❑ No effect ❑ Some limited restrictions, but can function ❑ Need some assistance with daily activities
❑ Can not work ❑ Can not function without assistance ❑ Totally disabled

19. Lifestyle:

❑ Tobacco use:	❑ Past	❑ Present	❑ Occasional	❑ Moderate	❑ Heavy
❑ Alcohol use:	❑ Past	❑ Present	❑ Occasional	❑ Moderate	❑ Heavy
❑ Coffee, tea & soda use:	❑ Past	❑ Present	❑ Occasional	❑ Moderate	❑ Heavy

20. Family Medical History:

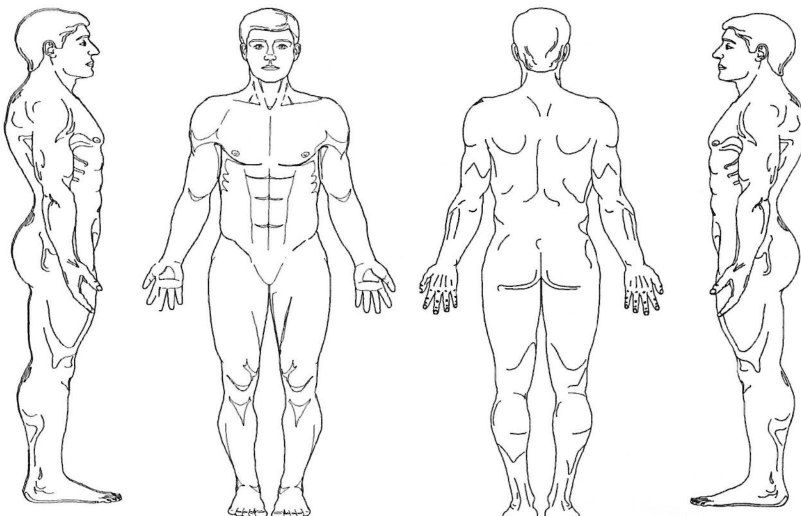
Father:	❑ Alive	❑ Deceased at Age ______	❑ Medical Conditions: ____________
Mother:	❑ Alive	❑ Deceased at Age ______	❑ Medical Conditions: ____________
Siblings:	❑ Alive	❑ Deceased at Age ______	❑ Medical Conditions: ____________
Relatives:	❑ Alive	❑ Deceased at Age ______	❑ Medical Conditions: ____________

YOUR PAST & PRESENT SYMPTOMS/CONDITIONS:

Symptom/Condition	Past	Present	Symptom/Condition	Past	Present	Symptom/Condition	Past	Present
Neck pain	❑	❑	Artificial Bones/Joints	❑	❑	Menstrual problems	❑	❑
Shoulder pain	❑	❑	High/Low blood pressure	❑	❑	Breast soreness/lumps	❑	❑
Arm/Elbow pain	❑	❑	Heart condition/pacemaker	❑	❑	Gynecological disorder	❑	❑
Wrist/Hand pain	❑	❑	Allergies/Asthma	❑	❑	Pregnancy	❑	❑
Upper back pain	❑	❑	Respiratory condition	❑	❑	Skin condition	❑	❑
Lower back pain	❑	❑	Sinus condition	❑	❑	Diabetes - Type I/Type II	❑	❑
Hip/Thigh pain	❑	❑	Stroke/Vascular disease	❑	❑	Excessive/Difficult urination	❑	❑
Knee/Leg pain	❑	❑	Gastrointestinal condition	❑	❑	Diarrhea/Constipation	❑	❑
Ankle/Foot pain	❑	❑	Kidney/Urinary Bladder	❑	❑	Prostate condition	❑	❑
Jaw pain/Jaw dysfunction	❑	❑	Liver/Gallbladder	❑	❑	Fainting/Seizures/Epilepsy	❑	❑
Headaches	❑	❑	Eye/Ears/Nose Condition	❑	❑	Dizziness/Ringing of ears	❑	❑
Arthritis/Swollen/Stiff joints	❑	❑	Excessive weight loss/gain	❑	❑	Anemia/Blood disorder	❑	❑
Skeletal anomaly/Scoliosis	❑	❑	Cancer/Leukemia	❑	❑	Plastic Surgery	❑	❑
Disc Disease/Herniation	❑	❑	Psychiatric condition	❑	❑	Sexual Disease/HIV+/AIDS	❑	❑

Use the symbols below to locate & describe your condition:

Aching	Numbness:	Pins & Needles	Burning:	Stabbing
xxxxxxx	- - - - - - - -	oooooooo	^^^^^^	••••••••



List any other medical condition(s) you've experienced:

____

List any surgeries &/or hospitalizations w/ dates :

____

List any accidents, sports injuries, falls, etc. w/ dates:

____

Clinical nutrition is an integral part of a comprehensive chiropractic treatment plan which improves many patient outcomes. If you are interested in maximizing your health potential by having a comprehensive nutritional evaluation, please check the appropriate box below. Please understand that an extensive examination and applicable bio-analytical laboratory testing are typically required.

❑ Yes, this is important to me ❑ No this is not an issue

____

Patient's Signature **Date**

SHERWOOD CHIROPRACTIC
Theodore S. Biniaris, D.C., M.S.
Chiropractic Physician
605 Sherwood Parkway
Mountainside, NJ 07092 - 2518
Tel (908) 233-5144 Fax (908) 368-8661

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

I. Uses and Disclosures

A. We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.
Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.
Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

B. We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

If we provide services to you while you are an inmate.
If we provide services to you in an emergency treatment situation.
If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition or death.
If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required to disclose your health information to the Food and Drug Administration.
If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.
If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.
If we are required to disclose your health information to a health oversight agency for oversight activities required by law.
If we are required to disclose your health information in response to a court order or a subpoena.
If we are required to disclose your health information to a law enforcement official.
If we are required to disclose your health information to a coroner, medical examiner or funeral director.
For research purposes.
If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEATH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

II. Your Rights

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.
Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.
Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures: Disclosures made to carry out treatment, payment and health care operations;

Disclosures made to you;
Disclosures made in our facility directory;
Disclosures made to individuals involved with your care;
Disclosures made for national security or intelligence purposes;
Disclosures made to correctional institutions or law enforcement officials; and
Disclosures made prior to the compliance date of the HIPAA Privacy Rule.
Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.
We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

Privacy Officer
Sherwood Chiropractic
605 Sherwood Parkway
Mountainside, NJ 07092
(908) 233-5144

V. How to Contact Us

If you would like further information about our privacy practices, please contact:
Privacy Officer
Sherwood Chiropractic
605 Sherwood Parkway
Mountainside, NJ 07092
(908) 233-5144

EFFECTIVE DATE OF NOTICE: April 13, 2003

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

______________________________ Patient Signature

______________ Date

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CHIROPRACTIC TREATMENT INFORMED CONSENT

Doctor Initials: Patient Initials:

____ ____ I have had been explained the purpose of & been given a description of the performance of spinal manipulative therapy (SMT) and other adjunctive therapeutic procedures relative to my condition. I understand that the results of treatment are not guaranteed.

____ ____ I hereby request and consent to the performance of SMT and other necessary procedures (including but not limited to: various modes of physical therapy & diagnostic x-rays) by qualified clinic personnel.

____ ____ I have been informed that some patients may experience discomfort or other symptoms after physical examinations, physical therapy modalities and SMT. If any discomfort or symptoms do occur, I will immediately contact my doctor. If I am out of town or unable to contact my doctor, I may present myself to an emergency room.

____ ____ Although studies have proven chiropractic care to be safer and more effective than medical care for neuromusculoskeletal conditions. (i.e. Manga Report) there are potential risks to treatment. The potential risks, albeit very slight, include but are not limited to: muscle strains, sprains, disc injury and cerebral vascular accidents. Studies which have quantified SMT risks:

1) If you drive about eight miles each way to get to your chiropractic appointment, you have a statistically **greater risk** of being seriously injured in a car accident while traveling to the Doctor's office than having a serious complication from a cervical spinal manipulation.

2) For the treatment of neck pain, NSAIDs (i.e. Advil, Motrin, Naprosyn, ...) were found to be associated with a very low risk of serious complications. However, the incidence of serious complications among people who received cervical spinal manipulation was determined to be up to **400 times lower** than those people who utilized NSAIDs for the treatment of neck pain.

____ ____ The doctor shall review the results of any laboratory tests or other diagnostic procedures performed outside of this office at the time of my next scheduled appointment.

____ ____ I have read the above consent, with the doctor. Our initials indicate that we have reviewed each section, item by item. I have also had an opportunity to ask questions about its content. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

______________________ ________ ______________________
Print Patient's Name Date Doctor's Signature

____
Patient's Signature (or parent/guardian)

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INSURANCE AUTHORIZATION / SIGNATURE ON FILE

- ☐ I authorize payment directly to my doctor.
- ☐ I understand that I am responsible for my bill.
- ☐ I authorize use of this form on all my insurance submissions.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- ☐ I authorize my doctor to release any information in order to judiciously resolve reimbursement issues with my insurance carriers.
- ☐ I permit a copy of this authorization to be used in place of the original.

Name: ______________________________ Medicare #: ______________
Please Print If Applicable

Signature: ______________________________ Date: ______________