Advanced Spine & Sports Care, LLC

504 Wolcott Road

Wolcott, CT 06716

Patient Health History

Today's Date / / **Signature of Patient** _____

Date of Birth: _____ **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Who may we thank for referring you? _____

Primary Care Physican Name/Address/Phone Number: _____

Is Injury Work or Auto Related?

Claim #_____ **Date of Injury:** _____ **Injury Report Filed?** _____

Attorney Name/Phone: _____

Adjuster Name/Phone: _____

Is patient covered by Insurance? ❑ Yes ❑ No Primary Insurance Type: _____

Subscriber Name: _____ **Policy #** _____

Group # _____ **Subscriber's SSN:** _____ **Date of Birth:**_____

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child

In Case of Emergency:

Name of Local Friend or Relative: _____ **Phone:** _____

What is reason for your visit? _____

What do you think caused this problem? _____

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

Please Help Us Identify your potential Health Risks By Placing Check below:

❑ AIDS/HIV	❑ Hepatitis (TYPE :_____)	❑ Immune	❑ Endocrine/Glandular (diabetes, etc.)
❑ Cancer	❑ Bleeding Disorders	❑ Stroke/TIA	❑ Circulatory Problems
❑ Heart Issues	❑ High Blood Pressure	❑ Neurological	❑ Gastrointestinal
❑Skin	❑ Ear/Nose/Throat	❑ Respiratory	❑Other: _____

Exercise: *(check one)* ❑ No Exercise ❑ Mild Exercise ❑ Occasional Vigorous ❑ Regular

Please Rate Stress Level: (None) 1 2 3 4 5 6 7 8 9 10 (Terrible)

Caffeine: ❑ None ❑ Coffee ❑ Tea ❑ Cola # Cups/Cans Per Day? _____

Does your complaint disrupt your sleep? ❑ Yes ❑ No

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form:

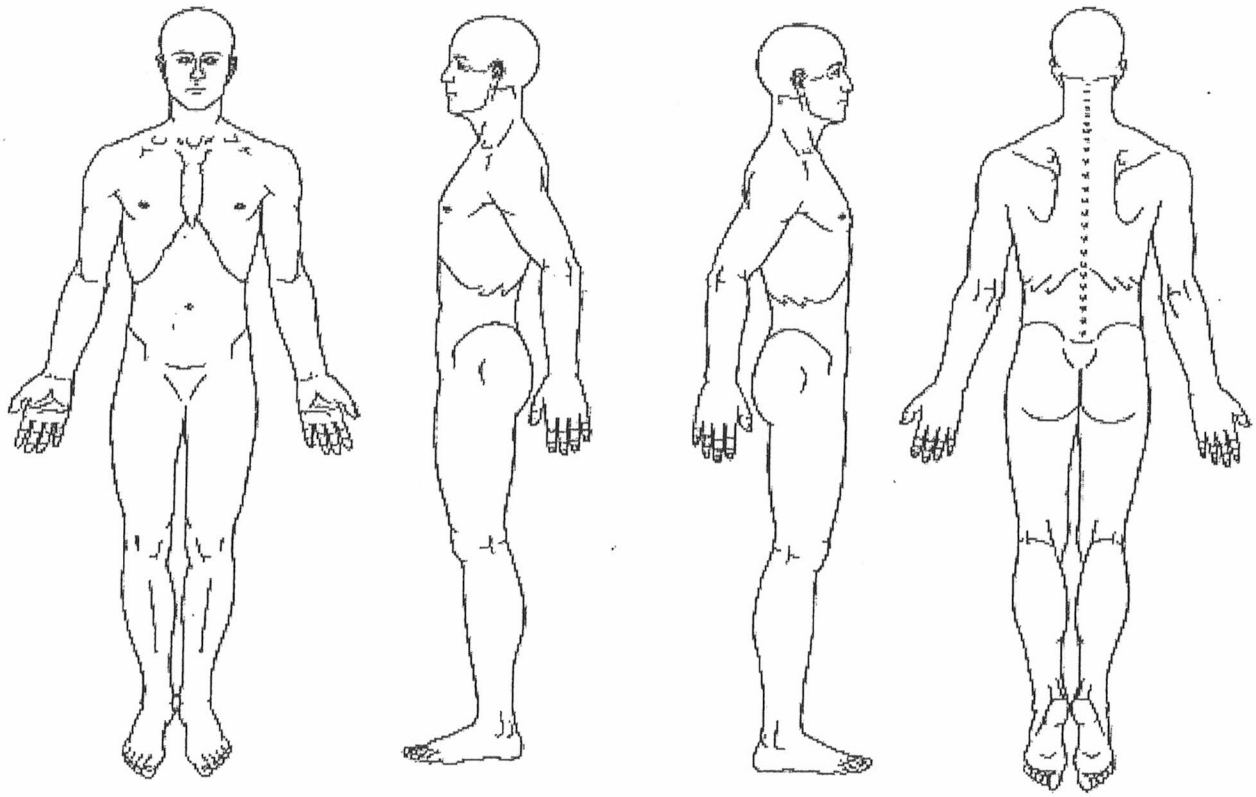
Patient Signature: _____ **Date:** _____

Name: _____ Date: _____/_____/_____ File: _____

Pain Diagram

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.
DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.

Numbness - - - - **Pins & Needles** oooo **Burning** xxxx **Aching** **** **Stabbing** ////



Please place a vertical mark on the line below to indicate the severity of your complaint.

Neck Pain No Pain |——————————————————| Worse Pain Imaginable

Low Back Pain No Pain |——————————————————| Worse Pain Imaginable

Other_____ No Pain |——————————————————| Worse Pain Imaginable

Patient Signature _____ Date _____/_____/_____

Advanced Spine and Sports Care, L.L.C.
504 Wolcott Road
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(203) 441-4371
NadimiChiro.com

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period _____.

Signature: _____ Date: ____/____/_____

Staff:_____ Date: ____/____/_____

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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.

Your Rights:

RIGHT OF ACCESS: You may inspect and request a copy of certain health information we have about you. We have forms for such requests. These requests must be made in writing and must be directed to our officer listed on the first page of this notice. We will provide a copy in format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If you are the recipient of electronic notice, you may obtain a paper copy upon request.

We will charge a reasonable, cost-based fee when asked to provide copies of your health information. Charges will include costs for copying at .50 cents per page, postage, and staff time at the rate of $15.00 per hour. If you request a summary of your health information, we will provide it, charging staff time at the hourly rate shown above. If you have any questions about our fees for these services, please contact us using the contact information provided.

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. Such requests must be made in writing and must include a reason to support the request. Under some circumstances, we may deny such a request, but you are entitled to a written response within 60 days of our receipt of your written request.

Rights to Request Restrictions: You may request that we restrict uses or disclosures or certain health information about you to carry our treatment, payment, or health care operations. We may not (and are not required to) agree to requested restrictions. We will not use or disclose any health information about you in violation or any restrictions that we agree to other than in providing emergency treatment.

Confidential Communications: Alternative Means, Alternative Locations: You may ask to receive communications of health information by alternative means or at an alternative location. We will accommodate all reasonable requests. You must provide this type of request to us in writing and provide an alternative method of contact of alternative address. We will provide an estimate of the fee for service in advance and ask that you provide information as to how payment will be handled.

Accounting of Disclosures: You have a right to receive an accounting of disclosures we have made of health information about you for the 6 years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations, and certain other disclosures. The first such accounting we provide within any 12 month period will be without charge to you. We will charge a reasonable, cost-based fee for each subsequent request for an accounting within a 12-month period. We will notify you in advance of this fee.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive the notice electronically, you may still obtain a paper copy. To obtain a paper copy, ask any Advanced Spine and Sports Care staff member.

Changes to This Notice: We reserve the right to change the terms of this notice and to make the changed notice provisions effective for all health information we have about you or could receive in the future. We will promptly revise, post, and distribute a revised notice whenever there is a material change to the uses or disclosures, individual rights, our legal duties, or other privacy practices discussed in the notice. Our privacy notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints: If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting:

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504 Wolcott Road
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You may also file a written complaint with the U.S. Department of Health and Human Services by contacting:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Washington, D.C. 20201
Toll Free: 1-877-696-6775

This privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

Acknowledgment of Receipt of Privacy Practices:

I, _____ have received a copy of Advanced Spine and Sports Care, L.L.C. notice of privacy practices.

_____ (Patient/Guardian Signature) Date: _____/_____/_____