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

APPLICATION FOR CARE AT CLEAR FAMILIES CHIROPRACTIC

Today's Date: __________________ HRN: ___________________

PATIENT DEMOGRAPHICS

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

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

Home Phone: (_____)_______-___________ Work Phone: (_____)_______-___________ Mobile Phone: (_____)_______-___________

E-mail Address: ____________________________Would you like to receive text reminders for your future appointments? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No

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

Employer: ____ Occupation: ____

Spouse's Name ____Spouse's Employer ____

Number of children and ages: ____

Name, Relationship, & Number of Emergency Contact: ____ (_____)_______-___________

HISTORY OF COMPLAINT

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity: 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _______________________	__________________	_______________	_________________	_______________	_________________
2. _______________________	__________________	_______________	_________________	_______________	_________________
3. _______________________	__________________	_______________	_________________	_______________	_________________
4. _______________________	__________________	_______________	_________________	_______________	_________________
5. _______________________	__________________	_______________	_________________	_______________	_________________

What daily activities are being restricted by your current health problems?

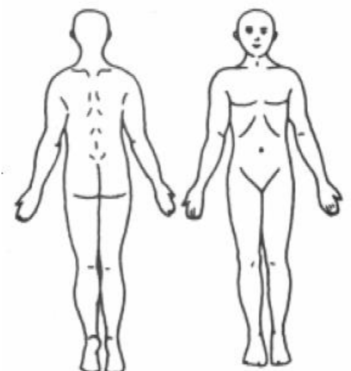
____

____

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **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? ___________________________________



PAST HISTORY

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

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

List all past surgical operations and the years they were performed:

____

____.

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

____

____.

Have you ever seen other doctors for the conditions you listed on the first page? ☐ Yes ☐ No

Chiropractor? ___________________________ Medical Doctor? ________________________ Other _______________________

If yes, who and when? ____

Are your health concerns the result of ANY type of accident? ☐ Yes ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

Have you ever been involved in an auto accident? ☐ Yes ☐ No **If yes, when?** ___________________________________

Have you ever been knocked unconscious? ☐ Yes ☐ No **If yes, when?** ____

Have you ever fractured a bone? ☐ Yes ☐ No **If yes, when?** ____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Exercise: → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. How does your present problem affect the following: Hobbies / Recreational Activities / Exercise Regime:

____

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 Clear Families 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 Clear Families Chiropractic for any and all services I receive at this office.

____ ______ - ______ - ______
Patient or Authorized Person's Signature Date Completed

____ ______ - ______ - ______
Doctor's Signature Date Form Reviewed

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: ______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Patient signature: ____ Today's Date: __/__/__

Continued on next page

REVIEW OF SYSTEMS

<u>Please mark **P** for in the **Past, C** for **Currently** have, or **N** for **Never**</u>

____ Headache	____ Pregnancy (Now)	____ Dizziness	____ Prostate Problems	____ Ulcers
____ Neck Pain	____ Frequent Colds/Flu	____ Loss of Balance	____ Sexual Dysfunction	____ Heartburn
____ Jaw Pain, TMJ	____ Convulsions/Epilepsy	____ Fainting	____ Digestive Problems	____ Heart Problem
____ Shoulder Pain	____ Tremors	____ Double Vision	____ Colon Trouble	____ High Blood Pressure
____ Upper Back Pain	___ Chest Pain	____ Blurred Vision	____ Diarrhea/Constipation	____ Low Blood Pressure
____ Mid Back Pain	____ Pain w/Cough/Sneeze	____ Ringing in Ears	____ Menopausal Problems	____ Asthma
____ Low Back Pain	____ Foot or Knee Problems	____ Hearing Loss	____ Menstrual Problems	____ Difficulty Breathing
____ Hip Pain	____ Sinus/Drainage Problem	____ Depression	____ PMS	____ Lung Problems
____ Back Curvature	____ Swollen/Painful Joints	____ Irritable	____ Bed Wetting	____ Kidney Trouble
____ Scoliosis	____ Skin Problems	____ Mood Changes	____ Learning Disability	____ Gall Bladder Trouble
____ Numb/Tingling arms, hands, fingers		____ ADD/ADHD	____ Eating Disorder	____ Liver Trouble
____ Numb/Tingling legs, feet, toes		____ Allergies	____ Trouble Sleeping	____ Hepatitis (A,B,C)

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name ____ Date __________________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache — Neck — Low Back

No pain ______________________________ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain ______________________________ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain ______________________________ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain ______________________________ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain ______________________________ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

____

____

____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

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 Clear Families 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.

____ ____/____/____ ☐ *Witness Initials*

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.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most 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 Person's Signature Date

CLEAR FAMILIES CHIROPRACTIC 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 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 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 contact Dr. Anthony Lopez at (228)-533-2733. If he is unavailable, you may make an appointment via our receptionist to see him 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***

CLEAR FAMILIES CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Clear Families 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.

____ ____________ ____________
Patient's Name (Print) DOB HR#

____ ____________
Patient's Signature Date

____ ____________
Witness Date