

INTAKE PAPERWORK for ADULTS

Today's Date: ____ / ____ / ____

Name: _____

Date of Birth: ____ / ____ / ____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Email Address: _____

Whom may we thank for referring you to KIDSPACE: _____

Emergency Contact:

Name: _____ Relationship: _____

Telephone: (Home) ____ - ____ - ____ (Cell) ____ - ____ - ____ (Work) ____ - ____ - ____

Medical Contacts:

Name of Medical Doctor/ Family Physician: _____

Telephone: ____ - ____ - ____

Please list any other health care providers (name, specialty, telephone): _____

Permission to contact for medical records: Yes No

CONSENT TO SHARE MEDICAL AND EDUCATIONAL RECORDS AND/OR DISCUSS MEDICAL HISTORY

Please share the names of your health providers & check whether or not you would like to share medical records with them:

- The practitioners at KIDSPACE Adaptive Play and Wellness
- The practitioners at Forest Family Medicine
- Primary Care Physician
- Other _____

Patient Signature: _____ Date: _____

Relationship to patient, if signed by someone other than patient _____

MEDICAL HISTORY:

Please list your health concerns in order of importance:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

What are your current symptoms: _____

When did they begin? _____

What brought on your symptoms? _____

Have you had any treatment for these symptoms? _____

What aggravates your symptoms?

- | | | |
|--|--|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Rolling over in bed | <input type="checkbox"/> Computer work |
| <input type="checkbox"/> Getting up from sitting | <input type="checkbox"/> Twisting | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Bending | <input type="checkbox"/> Coughing/sneezing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Lifting | <input type="checkbox"/> Neck movements |
| <input type="checkbox"/> Running | <input type="checkbox"/> Reaching | <input type="checkbox"/> Other: _____ |

What relieves your pain?

- | | | |
|-----------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Laying down | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Stretching | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Cold | |

What activities are difficult to perform?

- Yard work Household Chores Other: _____

Circle the least and most amount of pain (0 is least and 10 is most):

Low back pain: 0 1 2 3 4 5 6 7 8 9 10

Neck/upper neck pain: 0 1 2 3 4 5 6 7 8 9 10

Arm and leg pain: 0 1 2 3 4 5 6 7 8 9 10

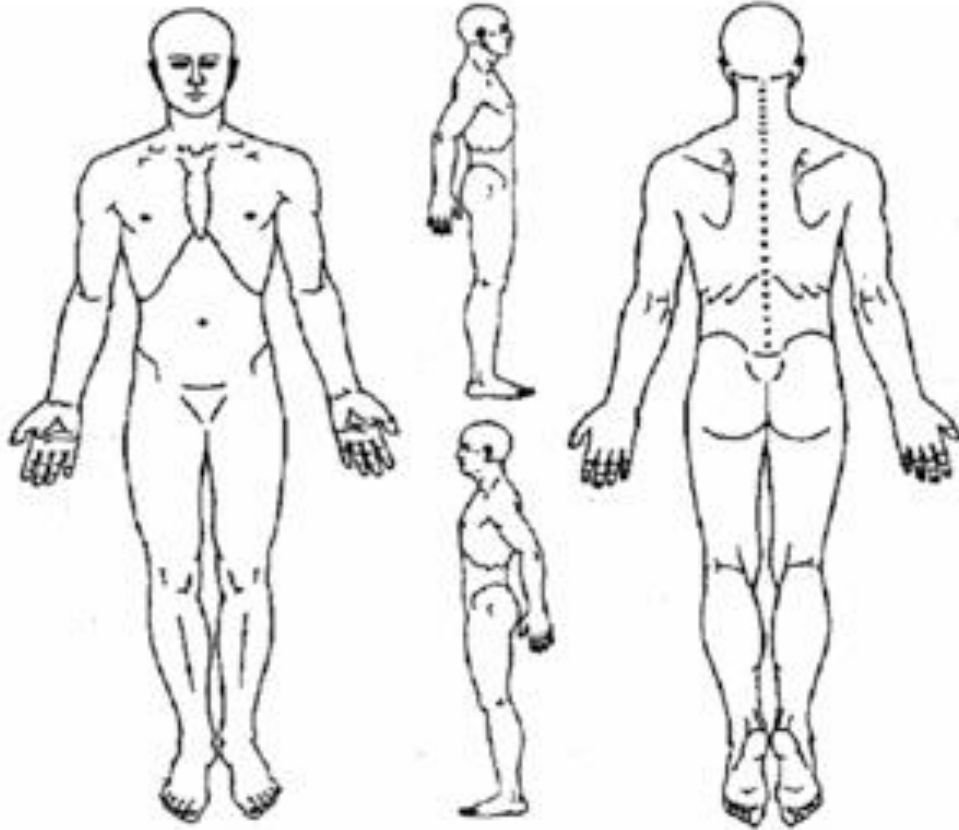
Headaches: 0 1 2 3 4 5 6 7 8 9 10

Symptoms are: Constant Intermittent

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	○ ○ ○ ○ ○	△ △ △ △	× × × ×	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	△ △ △ △	× × × ×	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	△ △ △ △	× × × ×	⊗ ⊗ ⊗ ⊗



Please describe any major illnesses, previous diagnoses, hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc. :

Date	Description

Please list any known allergies (drugs, food, environmental, chemical etc.) and the reactions from them:

Please list any and all current medications (prescription and over-the counter) & supplements (vitamins, herbs, homeopathic remedies):

Name of Drug/Supplement	Date Started	Dosage/Frequency	Prescribed for

FAMILY HISTORY

	Mother	Father	Brothers	Sisters	Maternal/Paternal Grandparents	Aunts/Uncles
<i>Check if applicable</i>						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma						
Kidney Disease						
Autoimmune Disease						
Other						

LIFESTYLE

Roles/ Relationships

Occupation: _____

Marital Status: Single Married Partnership Divorced Widowed

Children (List name, age, and gender): _____

Are you sexually active? Y N

Are you satisfied with your sex life? Y N

Do you and your partner(s) use contraception? Y N If yes, what type? _____

Smoking/Alcohol Intake/ Other Substances

Do you smoke cigarettes? Y N If yes, how many per day and for how long? _____

Previous smoking: How many years? _____ Packs per day? _____

Are you exposed to second hand smoke? Y N

How many alcoholic drinks per week? 1 drink = 5 oz. wine, 12 oz. beer, 1.5 oz spirits

None 1-3 4-6 7-10 >10

Have you ever been treated for alcoholism? Y N

Do you use recreational drugs? Y N If yes, what and how often? _____

Have you been treated for drug dependence? Y N

Exercise

Do you exercise (structured physical activity at moderate intensity for at least 30 minutes, 3 days per week, for the last 3 months)?
Y N

List the type of activity, number of sessions per week, and duration: _____

List any problems that limit activity _____

Sleep

How many hours per night? _____

Please check all that apply:

- Take naps
- Nightmares
- Restlessness
- Snore
- Trouble falling asleep
- Grinds Teeth
- Insomnia
- Wake at night How many times? _____
- Talks/Walks in sleep

Energy

How would you describe your energy level? Excellent Good Fair Poor

What time of day is your energy the best? _____ the worst? _____

Stress:

Rate your stress level between 1-10 (1 = lowest stress level, 10 = highest stress level) _____

Please list your biggest stressors _____

Who is in your support network? _____

Do you take vacations? Y N

Do you spend time outdoors? Y N

Enjoy your work? Y N

Diet:

How many ounces of water do you consume on a daily basis? _____ oz

Do you consume caffeinated beverages? Y N

If yes, what kind and how much? _____

Do you eat out often? Y N

Do you go on diets often? Y N

Are you satisfied with your current diet? Y N If no, please explain _____

Please provide a 24-hour diet recall:

Breakfast	
Lunch	
Dinner	
Snacks	

What is your current weight? _____

Height? _____

What is your ideal weight? _____

For the following section please indicate:

Y = a condition you currently have **P** = condition you've had in the past **N** = Never had

<p>MENTAL/EMOTIONAL</p> <p>Depression <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Mood swings <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Anxiety <input type="checkbox"/> Y <input type="checkbox"/> P</p> <p><input type="checkbox"/> N</p> <p>Suicidal <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Tension <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Memory Issues <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Poor concentration <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Seasonal Depression <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>ENDOCRINE:</p> <p>Hypothyroid <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Hypoglycemia <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Excessive Thirst <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Fatigue <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Heat/Cold Intolerance <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Diabetes <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Excessive Hunger <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>IMMUNE</p> <p>Reactions to vaccines <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Chronic Infections <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Slow wound healing <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Chronic fatigue syndrome <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Chronic swollen glands <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>NEUROLOGIC</p> <p>Seizures <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Muscle weakness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Paralysis <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Numbness/tingling <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Loss of memory <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Vertigo/dizziness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Easily stressed <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Loss of balance <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>SKIN</p> <p>Rashes <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Acne/boils <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Color change <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Lumps <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Eczema/hives <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Itching <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Perpetual hair loss <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Night sweats <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>HEAD</p> <p>Headaches <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Migraines <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Head Injury <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p>	<p>EYES</p> <p>Impaired vision <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Visual floaters <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Blurriness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Color Blindness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Double vision <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Cataracts <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Glasses/contacts <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Eye pain/strain <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Tearing/dryness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>EARS</p> <p>Impaired hearing <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Earaches <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Ringing <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Dizziness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>NOSE</p> <p>Frequent colds <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Congestions <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Sinus issues <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Nose bleeds <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Hay fever <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Loss of smell <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>MOUTH/THROAT</p> <p>Frequent sore throat <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Teeth grinding <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Gum problems <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Dental cavities <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Copious saliva <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Sore tongue/lips <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Hoarseness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Jaw/TMJ pain <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Bad breath <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>NECK</p> <p>Lumps <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Goiter <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Swollen glands <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Pain/Stiffness <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>RESPIRATORY</p> <p>Cough <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Asthma <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Pneumonia/bronchitis <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Shortness of Breath <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p>	<p>CARDIOVASCULAR</p> <p>Heart disease <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>High/low blood pressure <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Blood clots <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Rheumatic fever <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Swelling of ankles <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Angina <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Murmurs <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Palpitations <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Chest pain <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>GASTROINTESTINAL</p> <p>Trouble swallowing <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Change in thirst <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Nausea <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Vomiting blood <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Blood in stool <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Pain/cramps <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Belching/passing gas <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Black stools <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Jaundice (yellow skin) <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Liver Disease <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Heart burn <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Change in appetite <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Vomiting <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Constipation <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Gallbladder disease <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Ulcer <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Hemorrhoids <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>URINARY</p> <p>Pain with urination <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Frequency at night <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Frequent infections <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Increased frequency <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Inability to hold urine <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Kidney stones <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Change in urine odor <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>BLOOD/VASCULAR</p> <p>Easy bleeding/bruising <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Deep leg pain <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Varicose veins <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Anemia <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Cold hands/feet <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p> <p>Thrombophelbitis <input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N</p>
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FEMALES

Dates of last:

Menstrual period _____

PAP smear _____

Mammogram _____

Thermogram _____

Age of first menses: _____

Age of last menses: _____

Are your cycles regular Y N

Length of cycle: _____ Duration of menses: _____

Do you do self breast exams Y N

Are you currently pregnant Y N

Number of pregnancies: _____

Number of miscarriages: _____

Number of live births: _____

Number of abortions: _____

Bleeding between cycles Y P N

Heavy/excessive flow Y P N

Painful menses Y P N

PMS Y P N

Pain during intercourse Y P N

Clotting Y P N

Discharge Y P N

Endometriosis Y P N

Ovarian cysts Y P N

Breast lumps Y P N

Nipple discharge Y P N

Breast tenderness/pain Y P N

Cervical dysplasia Y P N

Abnormal PAP Y P N

Sexual difficulties Y P N

Gonorrhea Y P N

Chlamydia Y P N

Herpes Y P N

Syphilis Y P N

MALES

Dates of last:

Prostate exam _____

Hernias Y P N

Testicular Pain Y P N

Testicular Masses Y P N

Prostate Disease Y P N

Discharge/sores Y P N

Veneral Disease Y P N

Gonorrhea Y P N

Chlamydia Y P N

Herpes Y P N

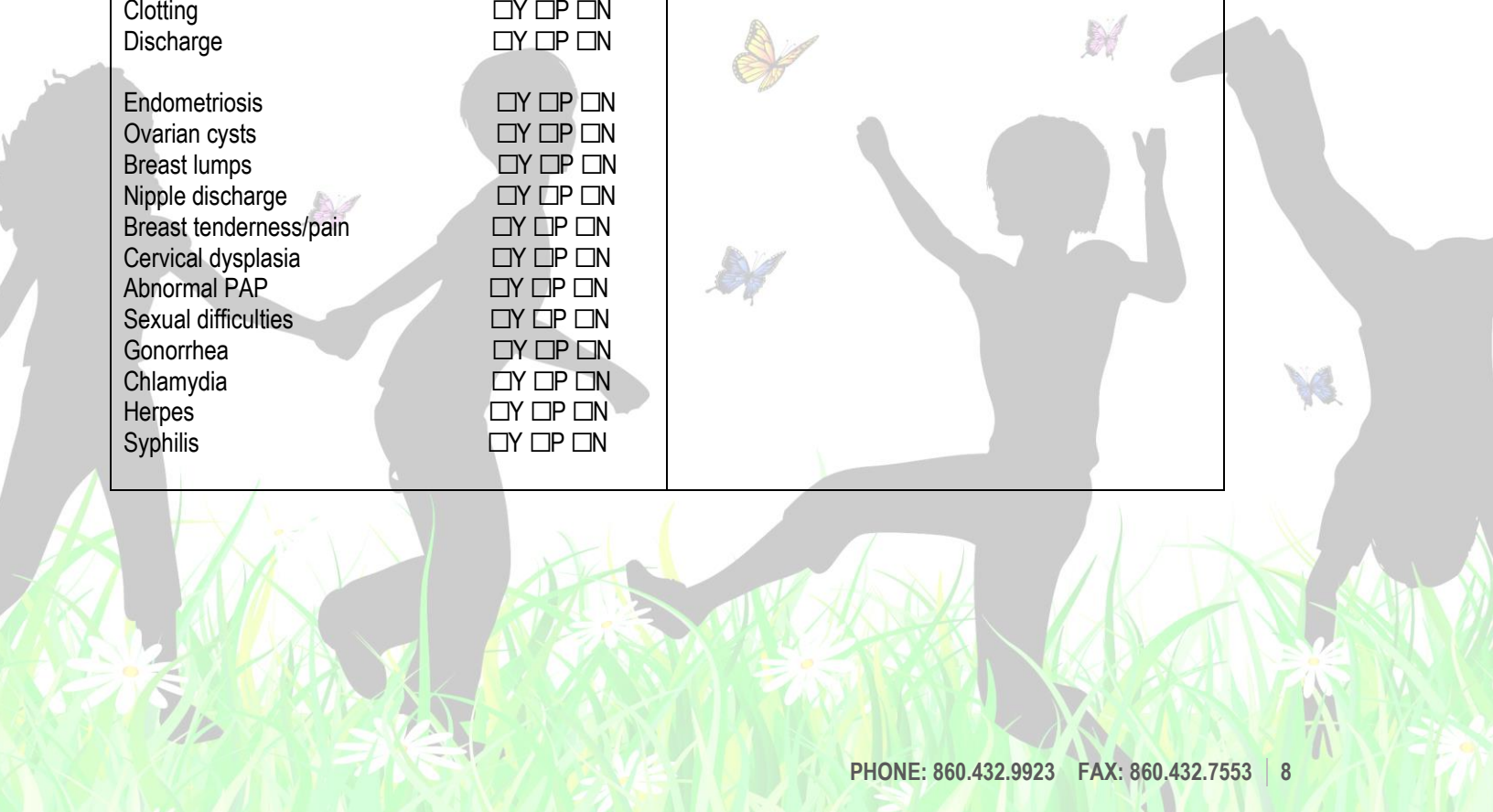
Syphilis Y P N

Ejaculation problems Y P N

Difficulty with erections Y P N

Pain with intercourse Y P N

Breast lumps Y P N



CONSENT FOR TREATMENT

It has been determined that your condition would benefit from one or more of the following evaluation and treatments modalities.

Physical Examination: To assist in diagnosis and treatment.

Comprehensive Laboratory Testing: To investigate biomedical medical needs to further assist with diagnosis and treatment.

Chiropractic manipulation: A high velocity and low amplitude technique designed to mobilize restricted joints in the spine and extremities. Please identify any areas you do not want manipulated.

Muscle energy technique/mobilization: Gentle mobilizations for restricted joints.

Soft Tissue work: Gentle massage to release tight muscles, fascia, and trigger points.

CranioSacral therapy: Gentle hands-on therapy to relieve deep body tension, pain and dysfunction.

Stretching: Used to elongate tight muscles.

Exercises: Palliative or strengthening exercises demonstrated in office for home use.

Homeopathic Supplements/Bach Flower Remedies

Nutrition: Nutritional counseling and therapeutic diets.

Botanical Medicine: Botanical (herbal) substances may be prescribed as teas, alcoholic tinctures, nonalcoholic tinctures, capsules, powders, tablets, creams, salves, or ointments.

Homeopathic Medicine: Diluted quantities of plant, mineral, or animal substances that strengthen the internal defense system to improve the patients general level of health.

Nutraceuticals: Vitamin and mineral supplementation

Lifestyle Counseling: Recommendations in improve health and well-being including: sleep, stress reduction techniques, etc.

Hydrotherapy: Different temperatures of water via hot and cold applications to the body may be used in office or prescribed as home treatments.

Counseling: Used to explore the connection between emotional health and physical health.

Potential Benefits: Restoration of health and body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, return to activity and prevention of disease progression.

Potential Risks: As with any health care procedure, adverse reactions may occur including: reactions to prescribed herbs and supplements, side effects of natural medications, and inconvenience of lifestyle changes, short-term aggravation of symptoms of muscle and ligament pain. Although uncommon, rib fractures have been known to occur following manual therapy. There are reported cases of stroke associated with visits to chiropractors and primary care doctors. The most current research indicates a temporal relationship between the occurrence of a stroke and a preceding visit to either a chiropractor or a primary care physician. You are being informed of this reported association because strokes can result in serious neurological impairment or death. The incidence of stroke associated with cervical manipulation is exceedingly rare and are estimated to occur between one in 1 million and one in 5 million adjustments. When nutritional, lifestyle, or any ancillary recommendations are suggested by your health care provider to enhance the healing process, material risks will be discussed on an individual basis.

Alternatives to treatment: There are other treatment options that may benefit your condition.

Notice to Pregnant Women: all female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present a risk to the pregnancy and fetus.

You are responsible for informing our providers of any relevant information or changes that affect your health. Should privileged information be shared via text message or email, your provider will make every effort to maintain privacy but text messaging and emailing are not encrypted or HIPAA-approved means of communication.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided my health care providers is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs I may be taking. With this knowledge, I voluntarily consent to the above procedures. I acknowledge that no guarantees of cure or improvement of my condition have been made. I understand that I am free to withdraw my consent and to discontinue treatment at any time. I understand that a record will be kept of health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted by law. I have read and understood the above explanation examination and treatment procedures. I have discussed it with Sharon A. Vallone, DC FICCP, Faraneh Carnegie-Hargreaves, DC or Lindsey Wells, ND and have had my questions answered to my satisfaction. I hereby give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

Printed Name _____

Signature _____

Date _____

PATIENT RESPONSIBILITIES

We agree to be financially responsible for all charges incurred at this office. We will make payment as required at the time of service. Should collection efforts be necessary to collect money owed, **a 15% interest charge will be added to the balance due.** We are liable for any cost incurred by the office in collection efforts.

CANCELLATION POLICY

If you are unable to make your appointment, please provide at least 24-hour notice of cancellation. **A cancellation fee of \$50 will apply for appointments cancelled with less than 24-hour notice.**

Signature

Date

Our office requires a credit card to be kept on file for any charges incurred.



SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will use and disclose your health information in order help you obtain payment for our services by allowing insurance companies to process insurance claims for services rendered to you by us or by other health care providers. Finally, we may disclose your health information for certain limited operational activities such as assessment, licensing, accreditation, and training of students.

Uses and disclosures based on your authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers or other financial information without your written authorization.

Uses and disclosures not requiring your authorization. In the following circumstances, we may disclose your health information without your written authorization. To family members or close friends who are involved in your health care. For certain limited research purposes. For purposes of public health and safety. To government agencies for purposes of their audits, investigations and other oversight activities. To government authorities to prevent child abuse or domestic violence. To the FDA to report product defects or incidents. To the law enforcement authorities to protect public safety or to assist in apprehending criminal offenders. When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patients you have the following rights: To have access to and/or a copy of your health information. To receive an accounting of certain disclosures we have made of your health information. To request that we communicate with you in confidence. To request that we amend your health information. To receive a notice of our privacy practices.

A COPY OF THE COMPLETE NOTICE IS AVAILABLE UPON REQUEST.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This document is to be signed by persons legally responsible for the patient’s medical decisions relative to the treatment situation.

We, _____, hereby acknowledge that we have been provided with a copy of the Notice of Privacy Practices that describes how medical information about our child/guardian may be used and disclosed, and how we can access that information. We understand that if we have questions or complaints, I may contact: **Faraneh Carnegie-Hargreaves, DC, Karen Peck CTRS, CST, QST; Sharon A. Vallone, DC, FICCP; or Lindsey Wells, ND at 860.432.9923.**

We also understand that we are entitled to receive updates upon request if this office amends or changes its Notice of Privacy Procedures in a material way.

Patient Signature Date

This section is to be completed by our office, if unable to obtain written acknowledgement from patient.

I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable because:

- Patient declined to sign this written acknowledgement.
- Other (specify): _____

Name and title of employee Date