

HEALING HANDS CHIROPRACTIC, LLC

3 Hall Ave ♦ Wallingford CT 06492 ♦ 203-626-9994

CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Full Name _____ Date _____

Mailing Address _____
Street City State Zip

Home Phone () _____ Mobil Phone _____ Work Phone () _____

Social Security # _____ Driver's License # _____

Email address _____

Marital Status: M S W D Age _____ Birth Date _____ No. of children _____

Pregnant? _____ Height _____ Weight _____ Occupation _____

Occupation _____ Employer's Name and Address _____

Spouse Occupation/Employer _____

Name of person responsible for account _____

Do you have insurance that covers Chiropractic care? Yes No Do you have Medicare Coverage? Yes No

Name of Insurance Company _____ Group/Policy # _____

Address _____ Phone _____

Whom may we thank for referring you? _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Malton all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship (Self/parent/spouse) _____ Date _____

I. HEALTH CONCERNS

(Please list your health concerns according to their severity)

	Rate of Severity 1=Mild 10=Worst	Date started, for how long?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is present
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

What have you done for this condition? Was it of benefit? _____

I do (do not) have a family history of this or similar symptoms. (Please explain): _____

Is this condition interfering with your: Work _____ Sleep _____ Daily routine _____ Sports/exercise _____ Other _____

Which activities aggravate your condition? _____

Other Doctors seen for this condition:

“Limited Scope” Chiropractor (Focuses mainly on neck and back pain)_____

Wellness Chiropractor (Focuses on health and well-being as well as underlying cause of pain and health concerns)_____

Naturopath_____ Homeopath_____ Medical_____ Dentist_____ Other_____

Name/Address:_____

When? _____ What did they say was wrong? _____

What did they do? _____ Did it help? _____

Have you been “forced” or “felt the need” to make any “positive” changes in your life due to this pain, illness, condition, etc...? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc...) If so, what?

Are you unable to do certain activities that you would like to do because of your health? (i.e. sports, walk, pick up grandchildren, etc...) If so, what?_____

Have you had any surgery? (please include all surgery)

1. Type_____ When_____ Doctor_____

2. Type_____ When_____ Doctor_____

3. Type_____ When_____ Doctor_____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1. Type_____ When_____ Hospitalized: ___ Yes ___ No

2. Type_____ When_____ Hospitalized: ___ Yes ___ No

3. Type_____ When_____ Hospitalized: ___ Yes ___ No

Have you ever had x-rays taken? _____ When? _____ Where? _____

Area of the body:_____

Do you wear orthotics or heel lifts? Yes _____ No _____

II. CURRENT MEDICINE(S)

Please list ALL drugs you currently take or have taken in the past 6 months:

Name_____ Dosage_____ For what?_____

Name_____ Dosage_____ For what?_____

Name_____ Dosage_____ For what?_____

Name_____ Dosage_____ For what?_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take:

Name_____ For what?_____

Name_____ For what?_____

Name_____ For what?_____

Name_____ For what?_____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being and would you

be willing to make dietary changes if indicated? Yes _____ No _____ Maybe _____

Would you take food supplements if indicated? Yes _____ No _____ Maybe _____

III. HEALTH HISTORY

Mark the following conditions you may have had or have now (“-“ have had, “+” have now)

<input type="checkbox"/> Allergy	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eczema
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> HIV (AIDS)	<input type="checkbox"/> Gout
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Neuritis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Malaria	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Constipation	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Polio	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> Migraines	<input type="checkbox"/> Headaches	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Other: (Please Explain) _____					

IV. STRESSES

Please list your top three stresses in each area (remember stress is cumulative throughout our lives)

PHYSICAL: (Ex. Birth trauma, falls, injuries, sports, poor posture, computer work, hard labor, etc...)

1. _____ 2. _____ 3. _____

How do you grade your physical health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse___

EMOTIONAL/MENTAL: (Ex. Job/school stress, move, loss of loved one, abuse, divorce, financial, etc...)

1. _____ 2. _____ 3. _____

How do you grade you emotional/mental health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse___

CHEMICAL: (Ex. Fast food, artificial sweeteners, sugar, soda/pop, refined foods, alcohol, nicotine, household or commercial cleaners, pollution, pesticides, prescription drugs, antibiotics, over-the-counter drugs, etc...)

1. _____ 2. _____ 3. _____

How do you grade your chemical health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse___

V. CONCLUSION

Is there anything else which may help to better understand you, which has not been discussed?

Why are you here at this point in time? _____

Print Patient Name _____ Date _____

Signature _____
(Patient/Parent/Guardian)

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation, if necessary. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

(signature)

(date)

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank because of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For Office Use Only

Height: _____ Weight: _____ Blood Pressure: _____/_____

Healing Hands Chiropractic LLC

HIPAA COMPLIANCE SIGNATURE PAGE

Patient Name _____

Person/s you are **releasing** information to: _____

***Please choose one** _____ Any information _____ Billing information only

Person/s **not to release** information to: _____

Patient or Guardian
signature _____

Print Name if Guardian _____ Date _____

A copy of complete HIPPA policy is available by request.

_____ Refused to sign _____