

# Clukey Family Chiropractic

"A Family Wellness Center"

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Names & Ages of Children \_\_\_\_\_

Name and Number of Emergency Contact \_\_\_\_\_

*Whom may we thank for referring you to this office?* \_\_\_\_\_

## CASE HISTORY

Please identify the condition(s) that brought you to this office:

Primary: \_\_\_\_\_ Second: \_\_\_\_\_

Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

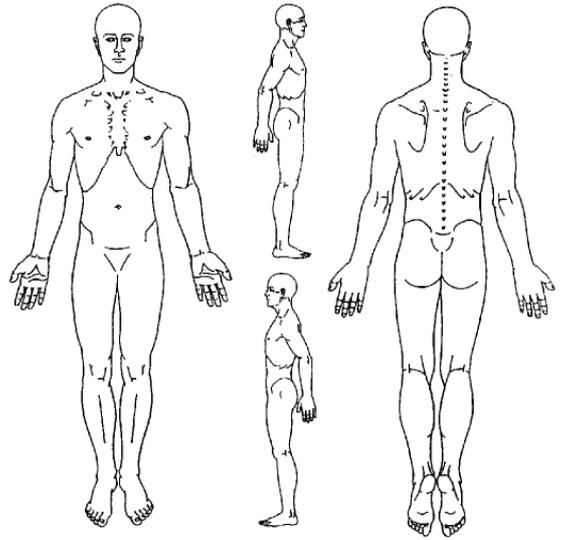
Rate the severity of the above complaint(s) on a scale of 0-10:

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

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

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

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



\*Fill in all areas of discomfort on the figure to the right by using

the following letters:     **A** – aching     **B** – burning     **D** – dull

**N** – numbness     **R** – radiating     **S** – sharp     **T** – tingling

When did this problem begin? \_\_\_\_\_ Has it ever occurred before?      Yes    No

The problem is worse in:    AM    PM    At Night    With Activity (bending, lifting, sitting, standing)

Frequency of complaint is:    Constant    On/off during day    Comes and goes throughout the week

Is condition related to?    Auto Accident    Work Injury    No Injury    Other \_\_\_\_\_

Has this condition ever been treated by anyone in the past?    No    Yes, Dr. \_\_\_\_\_ Date \_\_\_\_\_

How long were you under care? \_\_\_\_\_ What were the results? \_\_\_\_\_

What makes you feel better? \_\_\_\_\_ What makes you feel worse? \_\_\_\_\_

Have you ever received chiropractic care?    No    Yes, Dr. Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

**DAILY ACTIVITIES**

What kind of effect does your condition have on the following? Check all that apply.

Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Exercising	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Recreational Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting / Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Please label the lines below by using the following letters: **C** – current **P** – past (over 6 months ago) **N** – never

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Circulation	<input type="checkbox"/> Colon Trouble
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression	<input type="checkbox"/> Digestion	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Ear / Hearing	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Fainting	<input type="checkbox"/> Flu/frequent colds	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Headache	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Hepatitis (A, B, C)	<input type="checkbox"/> Hormone
<input type="checkbox"/> Impotence	<input type="checkbox"/> Irritability / Mood	<input type="checkbox"/> Jaw pain / TMJ	<input type="checkbox"/> Kidney Problem	<input type="checkbox"/> Liver Problem
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Low Energy	<input type="checkbox"/> Lung Problem	<input type="checkbox"/> Muscle Spasm	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Nose Bleed	<input type="checkbox"/> Rash / Skin	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Sinus	<input type="checkbox"/> Sleep
<input type="checkbox"/> Swollen Joint	<input type="checkbox"/> Tremors	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Weight Gain/Loss

**FEMALES ONLY:**  Irregular Period  Painful Period  No Period  Hot Flashes

Are you pregnant?  Yes  No  Not Sure

List all medications currently used:

Provide reason for use and length of time on medication:

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Check surgeries or procedures that apply.  I have never had any surgeries or procedures.

Appendix  C-Section  Chemotherapy  Gall Bladder  Heart

Hernia  Reproductive  Spine  Thyroid  Vaccinations

Other \_\_\_\_\_

List any conditions or diseases not previously mentioned \_\_\_\_\_

RESTRICTED ACTIVITIES CURRENT ACTIVITY LEVEL USUAL ACTIVITY LEVEL

1. \_\_\_\_\_ : \_\_\_\_\_

2. \_\_\_\_\_ : \_\_\_\_\_

3. \_\_\_\_\_ : \_\_\_\_\_

Rate your stress level on a scale of 0-10: \_\_\_\_\_ Cause of stress \_\_\_\_\_

Describe sleep patterns: \_\_\_\_\_ List any hobbies \_\_\_\_\_

Alcohol drinks/day _____	<u>EXERCISE</u>	<u>FAMILY HISTORY</u>	Spine	Cancer	Diabetes	Heart
Coffee cups/day _____	<input type="checkbox"/> None	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking cigarettes/day _____	<input type="checkbox"/> 3-4 times/week	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water cups/day _____	<input type="checkbox"/> Daily	Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Goals for Your Care:**

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- I want the Doctor to select the type of care appropriate for my condition
- Relief care:** Symptomatic relief of pain or discomfort
- Corrective Care:** Correcting and relieving the cause of the problem as well as the symptom.
- Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

On a scale of 1 to 10 with 10 being the highest, rate your commitment to getting rid of the problem: \_\_\_\_\_

Please specify any concerns that could interfere with your commitment (example: time, transportation, other)

\_\_\_\_\_

*Were You Aware That...*

- Doctors of Chiropractic work with the nervous system?  
No\_\_ Yes\_\_
- The nervous system controls all bodily functions and systems?  
No\_\_ Yes\_\_
- Chiropractic is the largest natural healing profession in the world?  
No\_\_ Yes\_\_

**Do you have Health Insurance?**  No (many of our patients do not)  Yes (please complete the box below)

Insured's Name _____	DOB _____ / _____ / _____	SSN _____ - _____ - _____
Insurance Company _____		Policy Number _____

If I am covered by health insurance, I understand and agree that health insurance policies are an arrangement between my insurance carrier and me. Whether I do or do not have insurance, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if insurance is applied I am responsible for any amount not covered or paid by my insurance (deductibles, copayments, denials, etc.) I acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Clukey Family Chiropractic for any and all services I receive. We also reserve the right to bill any balance due past 30 days to your credit card on file.

Patient Signature \_\_\_\_\_ Date Completed \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date Reviewed \_\_\_\_\_

**Notice of Privacy Practices (HIPAA)**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights.** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

**Your physician is not required to agree to a restriction that you may request.** If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

I authorize Clukey Family Chiropractic and it's agents to give information regarding my treatment at Clukey Family Chiropractic to family members, work associates or others over the telephone. I also authorized Clukey Family Chiropractic and it's agents to leave information regarding my treatment on my home, cellular, and office voicemail and other messaging systems that may be appropriate. This information may include, but not limited to, appointment reminders and incoming calls concerning your treatment and appointment times. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  WITNESS INITIALS

I hereby acknowledge receiving a copy of a one page document titled 'Clukey Family Chiropractic Office Policies' (next page). I have read 'Clukey Family Chiropractic Office Policies' in its entirety and have retained it for my personal records. This page is recognized by me as the signature page and will be retained by Clukey Family Chiropractic as evidence of my receiving and understanding this notice. I further acknowledge that any concerns regarding these policies, as well as all of my questions, have been answered by a member of the staff to my complete satisfaction.

PRINT NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  WITNESS INITIALS

# CLUKEY FAMILY CHIROPRACTIC OFFICE POLICIES

## Welcome to Clukey Family Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read the "Office Policies", if you have any questions or any of these policies are unclear to you or you would like further explanation before submitting your "Application for Care", please let our front desk receptionist know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness creates a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make positive changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters in the open bay adjusting area. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in private. These consultations must be scheduled in advance!

□ **YOUR CARE** – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Clukey Family Chiropractic has only one goal. It is important that each patient understand both the objective and the method that it will be used to attain it. This will prevent any confusion or disappointment. Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine. Health: A 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 to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area. 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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

□ **FIRST THING FIRST** – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the cause of your condition and exact location of any subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to reduce and remove subluxations while teaching patients what they need to do in addition to being adjusted to experience amazing health for a lifetime.

□ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your consultation and spinal evaluation, you will be scheduled for a 'Patient's Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients at Clukey Family Chiropractic. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning care options.

~ PATIENT RETAINS THIS PAGE FOR PERSONAL RECORDS ~