Cranbury Chiropractic Center, LLC

Initial History Intake

Today's Date: _____

Name: _____ Date of birth: _____

Address: _____ City: _____ ST: _____ Zip: _____

Best phone number to reach you: _____

Email: _____

Employer Name/ Address: _____

What is the reason for today's visit? _____

Is today's visit the result of an auto accident? ☐ YES ☐ NO

On the job injury? ☐ YES ☐ NO

If YES, what is the date of your injury? _____ Date symptoms began? _____

If you have health insurance, what is the company? _____

Briefly describe your symptoms: _____

_____

How did your symptoms start? _____

_____

Please rate your average pain intensity on the scale below:

Last 24 hours: **no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain**

Past week: **no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain**

How often are you experiencing symptoms?

( ) Constantly (76-100% of the time) ( ) Frequently (51-75% of the time)
( ) Occasionally (26-50% of the time) ( ) Intermittently (1-25% of the time)

How much have your symptoms interfered with your usual daily activities? (Including both work outside the home and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How would you rate your overall health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair

☐ Poor

What activities aggravate your pain? _____

Past History: Have you consulted other Doctors for this problem? ☐ YES ☐ NO

If YES, who? _____

Have you had any significant auto accidents or falls? _____

Please list any surgical procedures you have had: _____

Please list all prescription medications you are taking: _____

_____

Please list all over the counter medications/vitamin supplements you are taking: _____

_____

Family History: Father: ☐ Diabetes ☐ Hypertension ☐ Dementia ☐ Cancer

Mother: ☐ Diabetes ☐ Hypertension ☐ Dementia ☐ Cancer ☐ Osteoporosis

Social History: Marital Status: _____ Occupation: _____

( ) Nonsmoker (never smoked) ( ) Ex-smoker ( ) Current smoker How many packs/day? _____

ROS	Please check all CURRENT positive findings:	Past Med History
Constitutional:	( ) Significant recent weight loss/gain ( ) Fevers ( ) Fatigue	( ) Cancer
Eyes:	( ) Eye pain ( ) Double vision	( ) Dry eyes
ENT:	( ) Hearing loss ( ) Trouble swallowing	
Cardiovascular:	( ) Chest pain ( ) Swelling in feet	( ) Hypertension ( ) Pacemaker
Respiratory:	( ) Trouble breathing ( ) Chronic cough ( ) Coughing up blood	( ) Asthma
		( ) COPD ( ) Sleep apnea
Gastrointestinal:	( ) Loss of bowel control ( ) Nausea ( ) Vomiting ( ) GERD/reflux ( ) Ulcers	
Genitourinary:	( ) Loss of bladder control ( ) Increased urinary frequency	
		( ) Kidney/ Liver disease
Skin:	( ) Lacerations ( ) Bruises	

Musculoskeletal: ( ) Muscle weakness ( ) Muscle cramps
( ) Implants, screws, pins, artificial joints
( ) Osteoporosis ( ) Rheumatoid Arthritis

Psychiatric: ( ) Disturbed sleep ( ) Memory loss ( ) Anxiety ( ) Depression

Endocrine: ( ) Increased thirst ( ) Increased urination ( ) Diabetes ( ) Thyroid disease

Neurological: ( ) Recent falls ( ) Numbness or tingling to extremities ( ) Headaches ( ) Migraines
( ) Seizures ( ) Stroke

Hematologic: ( ) Prolonged breathing ( ) Easily bleeding/ bruising ( ) Blood clots ( ) DVT ( )
Pulmonary Embolism ( ) Ever taken blood thinners?

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ White ☐ American Indian ☐ Black ☐ Native Hawaiian

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Is there anything else you would like the doctor to know about today's visit?

_____

Signature: _____

Date: _____

Cranbury Chiropractic Center LLC
Dr. Paul L. Miller

Confidential Patient Health Information

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a compliance officer has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our compliance officer about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor has the right to refuse to give care.

Informed Consent for Chiropractic Spinal Manipulation, Diagnostic X-Rays and Treatment, Authorization and Release

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities (including but not limited to ultrasound, muscle stimulation, interferential, ice, heat, therapeutic exercises and/or traction) and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by or under the orders of the licensed doctors of chiropractic of the Cranbury Chiropractic Center LLC or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

Point of Notation:
Over the last several years in CT there has been some media statements that have claimed there is a risk of stroke with a chiropractic neck adjustment. The best scientific evidence (Journal Spine Feb. 2008) and a comprehensive review of the scientific data conducted by the Board of Chiropractic Examiners of the CT Department of Public Health in 2010 determined that no such risk exists. Please be sure to discuss this with the doctor should you have any additional concerns.

Cranbury Chiropractic Center LLC
Dr. Paul L. Miller

Confidential Patient Health Information

I authorize payment of insurance benefits directly to the Cranbury Chiropractic Center LLC. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize the Cranbury Chiropractic Center LLC to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.
I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature: _____ Date: ___/___/___

Printed Name: _____

Witness Signature _____ date _____

Witness Printed Signature _____

Consent to Treatment of a Minor Child:

I hereby authorize the doctors of the Cranbury Chiropractic Center, and/or whomever they may designate as assistants, to administer treatment as deemed necessary to _____.

Signature of Parent or Legal Guardian: _____ Relationship: _____

Date: _____/_____/_____ Witness signature: _____

_____

_____

Patient questions, Doctor/patient exchange:

Doctor's Signature _____ date _____

This form will be placed in the patient's chart and maintained for 6 years