Scoliosis Treatment - New Patient Paperwork

Today's Date: _____ Referred by: _____

PATIENT INFO

Name: _____ Birth Date: ___ / ___ / ____ Age: _____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____
Social Security #: _____ Driver's License #: _____
Employer: _____ Occupation: _____
Name of Spouse/Parents: _____

Emergency Contact Name: _____ Phone: _____
Relationship to Patient: _____

HISTORY OF SCOLIOSIS DIAGNOSIS OR CONDITION

When was Scoliosis first observed? _____

Diagnosed by Doctor/Therapist? ☐ No ☐ Yes When? By Whom? _____

Do you know details about your Scoliosis curves (size, location, etc.)? ☐ No ☐ Yes If yes, explain below:

Have you had any Xrays of Scoliosis? ? ☐ No ☐ Yes
If teenager, have you experienced a 'growth-spurt'? ☐ No ☐ Yes If yes, When? _____
If teen female, have you started menstrual cycle? ☐ No ☐ Yes If yes, When? _____

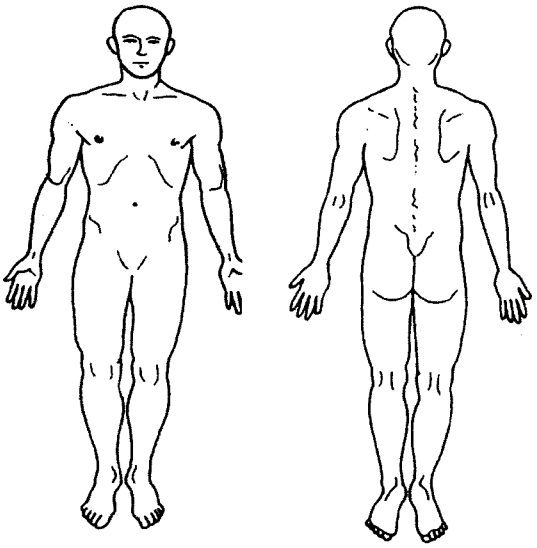
How does SCOLIOSIS affect your life? _____

Please identify ALL PAST / CURRENT conditions that may be contributing to your symptoms in the chart below:

	How Long Ago:	Type of care received:	By Whom:
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

FAMILY HISTORY

Does anyone in your family suffer with Scoliosis or other spinal conditions? ☐ No ☐ Yes If Yes, who:
☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son ☐ Daughter ☐ Grandmother ☐ Grandfather ☐ Other
Describe: _____



Please mark the areas on the diagrams to the left with the following letters to describe your symptoms:

R= radiating, **B**= burning,
D= dull, **A**= aching, **N**= numbness,
S= sharp/stabbing, **T**= tingling, **W**= weakness

Do you have any problems with BALANCE or ORIENTATION?

☐ No ☐ Yes ☐ Maybe If yes, How?

_____

_____

List any **PAIN** or other **SYMPTOMS you have?**

1.) _____
2.) _____
3.) _____
4.) _____

Please rate your complaint by circling below:

No Pain 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - **Worst**
No Pain 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - **Worst**
No Pain 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - **Worst**
No Pain 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - **Worst**

When is it at it's WORST? ☐ AM ☐ PM or _____

How long does it last? ☐ Constant ☐ Off/On throughout day ☐ Comes/Goes throughout week

What relieves your symptoms? _____

What makes them worse? _____

Have you been treated by anyone in the past? ☐ No ☐ Yes If yes, by whom (type of care)?

_____

_____

If so, how long under care? _____ What were the results? _____

_____

_____

Name of previous Chiropractor/Doctor/Therapist? _____ ☐ N/A

Does your condition stop you from doing certain activities or actions? ☐ No ☐ Yes If yes, please list:

_____

_____

IF THE PATIENT HAS ANY PREVIOUS **XRAYS OR MRI STUDIES** WE WILL NEED TO GET COPIES OF THOSE FOR OUR ASSESSMENT BEFORE WE CAN START TREATMENT.

Although patients can have similar Scoliosis presentations, it's important to remember that every patient is unique in how their Spine functions with regard to their specific condition. We evaluate every patient to understand exactly how his/her Spine functions and will respond to treatment.

Signature of Patient or Parent/Guardian: _____ Date: _____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ **No.:** _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Drug Abuse
- ❑ _____

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

Patient's Signature _____

•••••••••••••••••••• DO NOT WRITE BELOW THIS LINE ••••••••••••••••••••

_____

_____

_____

_____

Patient Accepted? ❑ Yes ❑ No Doctor's Signature _____

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 Restoration 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. I also consent to having my x-rays used anonymously for patient education and teaching needs.

_____ _____ ☐

Patient or Authorized Person's Signature Date Witness Initials

REGARDING: X-rays/Imaging studies:

FEMALES ONLY → Please read carefully, 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 ____ - ____ - ____

☐ 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.

_____ _____ ☐

Patient or Authorized Person's Signature Date Witness Initials

NOTICE OF PRIVACY PRACTICES

Restoration Chiropractic
503 Main St.
Belton, MO 64012
(816) 425-5578

Effective Date: September 23, 2013

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

This Notice of Privacy 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 PHI. "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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.
Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.
Health Care Operations: We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made **only** with your consent, authorization or opportunity to object unless required by law. You may revoke the 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 HEALTH INFORMATION RIGHTS

The following are statements of your rights with respect to your protected health information.

Right to Obtain a Paper Copy of This Notice: You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in EHR software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your **medical information, we may** charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record. You have a right to have this information with-in 30 days of receipt of your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information. To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the equest. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years; • disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. You have a right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

Research. We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

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 protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature: _____ Date_____ Print Name: _____