CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State: _____ Zip: _____

Home Phone _____

Cell Phone _____

Email _____

Sex ❑ M ❑ F Age _____ Birthday _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

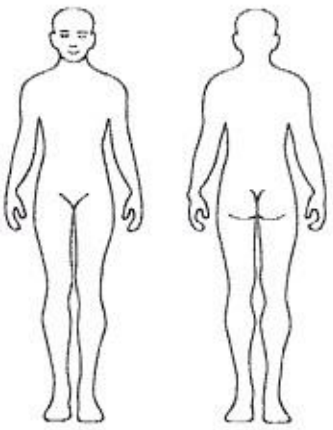
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

0 = NO SYMPTOMS; 10 = INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

❑ Numbness ❑ Sharp

❑ Tingling ❑ Shooting

❑ Stiffness ❑ Burning

❑ Dull ❑ Throbbing

❑ Aching ❑ Stabbing

❑ Cramping ❑ Swelling

❑ Nagging ❑ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other _____	❑	❑	❑	❑

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

0 = NOT COMMITTED; 10 = VERY COMMITTED

Signature: _____ Date: _____

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Childhood Illness
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ❑ Elbow/Wrist/Hand Issues
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues
- ❑ Immune Issues
- ❑ Lymphatic Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Shoulder Issues
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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

EFFECTIVE: September 23, 2013

We are required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. We are required to follow the practices described in this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time. If we change our notice, we will post the revised notice in the facility and will have them available upon request. You can receive a copy of the current notice at any time. This Notice describes how we have extended certain protections to your PHI and how, when, and why we may use and disclosure your PHI. With certain exceptions, we will use or disclose your PHI in the minimum necessary manner to accomplish the intended purpose of the use or disclosure. We will share PHI as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. To the extent there is stricter State or federal law regulating the privacy of your PHI, we will comply with the more strict provisions of law.

You may view this Notice or any new notices on our website at www.uppercervicalmaine.com

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We are committed to maintaining the confidentiality of your health information. Your health information may be used and disclosed for purposes of treatment, payment, and health care operations. Outside of these permitted uses, we must have your written and signed authorization unless the law permits or requires the use or disclosure without your authorization. You have the right to revoke that authorization in writing except to the extent any action has been taken in reliance on the authorization.

Treatment. We may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

Payment. We may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

Health care operations. We may use and disclose your PHI to operate our business. For example, we may use your PHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations as permitted by law.

Business Associates. It may be necessary for us to provide your health information to certain outside persons or entities that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

Treatment Alternatives. We may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Individuals Involved in Your Care or Payment of Your Care. We may, subject to specific limitations, disclose your PHI to friends or family involved in or who help pay for your health care.

As Required by Law. We will disclose your PHI when required to do so by federal, state or local law.

Appointments, Services and Fundraising. We may contact you to provide appointment reminder, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate your reasonable requests, to receive communications regarding your health information from us by alternative means or at alternative locations. You may request such confidential communication by sending your written request to the Privacy Officer. We may contact you to support our fundraising efforts. You may opt-out of receiving any further fundraising communications from our facility by notifying our Privacy Officer at (207) 846-5100 in writing of your name, address, and request to be removed from our fundraising mailing and contact lists.

THE FOLLOWING USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR AUTHORIZATION: (i) uses and disclosures for marketing purposes; (ii) uses and disclosures that constitute the sale of protected health information; (iii) uses and disclosures of psychotherapy notes; and (iv) other uses and disclosures not described in this notice.

SPECIAL USE AND DISCLOSURE SITUATIONS

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, accrediting

organizations such as The Joint Commission, required abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donations, worker's compensation purposes, and emergencies.

We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.

We may use or disclose your medical information for research purposes but only with your prior authorization or a proper waiver of authorization from an IRB or Privacy Board.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Restrictions on Use and Disclosure of Individual Health Information. You have the right to request that we restrict how we use and disclosure your health information. These restrictions must be made in writing to our Privacy Officer and signed by you or your representative. We are not required to agree to your restrictions. We cannot agree to limit uses/disclosures that are required by law. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination. You may terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer.

Access to Individual Health Information. You have the right to inspect and copy your health information. All such requests must be made in writing to our Privacy Officer and signed by you or your representative. We must make PHI available in electronic format upon request and where available. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendments to Individual Health Information. You have the right to request that your health information be amended or corrected. We will respond within 60 days unless an extension is taken. In certain cases, we may deny your request for amendment and you will be given written notice that will explain the basis and your right to appeal. You may also submit a statement of disagreement and we may prepare a rebuttal that will be provided to you. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment. If we make an amendment, we may notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. You may obtain a Request for Amendment form from the Privacy Officer.

Accounting for Disclosures of Individual Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us after April 14, 2003. Requests must be made in writing and signed by you or your representative. Request for Accounting forms are available from the Privacy Officer. The first accounting in any 12-month period is free; you will be charged a reasonable fee for each subsequent accounting within the same twelve-month period. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

Notification of Breach. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your PHI.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this or any revised Notice and/or an electronic copy by email upon request to the Privacy Officer.

Right to File a Complaint. If you believe that we may have violated your privacy rights, or you disagree with a decision we about access to your PHI, you may file a complaint with the Privacy Officer listed below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, Washington D.C. 20201 or call 1-877-696-6775. There will be no retaliation for filing a complaint.

Right to provide an authorization for other uses and disclosures. We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Contact: Privacy Officer

If you have questions about this Notice or any complaints about our privacy practices, please contact our privacy officer at 207-846-5100.

A COPY OF THIS NOTICE OF PRIVACY PRACTICES WILL BE MADE AVAILABLE UPON REQUEST.

P \Health Law Department\FINAL HIPAA Omnibus Rule\Physician Practices\Model Physician Practice Notice of Privacy Practices

I have read and understand the above privacy policies of this office

Signature _____

Name _____ Date _____

Patient Consent For Use & Disclosure Of Protected Health Information

With my consent, Yarmouth Spinal Care (YSC) may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Yarmouth Spinal Care Notice of Privacy for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. YSC reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to YSC. With my consent, YSC may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care. With my consent, YSC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. By signing this form, I am consenting to YSC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, YSC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

Signature

Date

Authorization to Pay/Release Is Granted to: Yarmouth Spinal Care

APPOINTMENT REMINDERS and COMMUNICATION

I hereby consent and state my preference to have my physician, Dr. Scott Glocke, and other staff at YSC communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill-in the ones you agree to):

Phone number_____

Email_____

Text_____

I give permission to contact me, relative to appointment reminders only, by the following methods:

Phone message at the following number_____

Email messages at the following email address_____

Text messages at the following phone number_____

YARMOUTH
SPINAL CARE

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 towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able 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 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 to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal evaluation 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 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. 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 objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore 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.

X-Ray Release (signature required)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

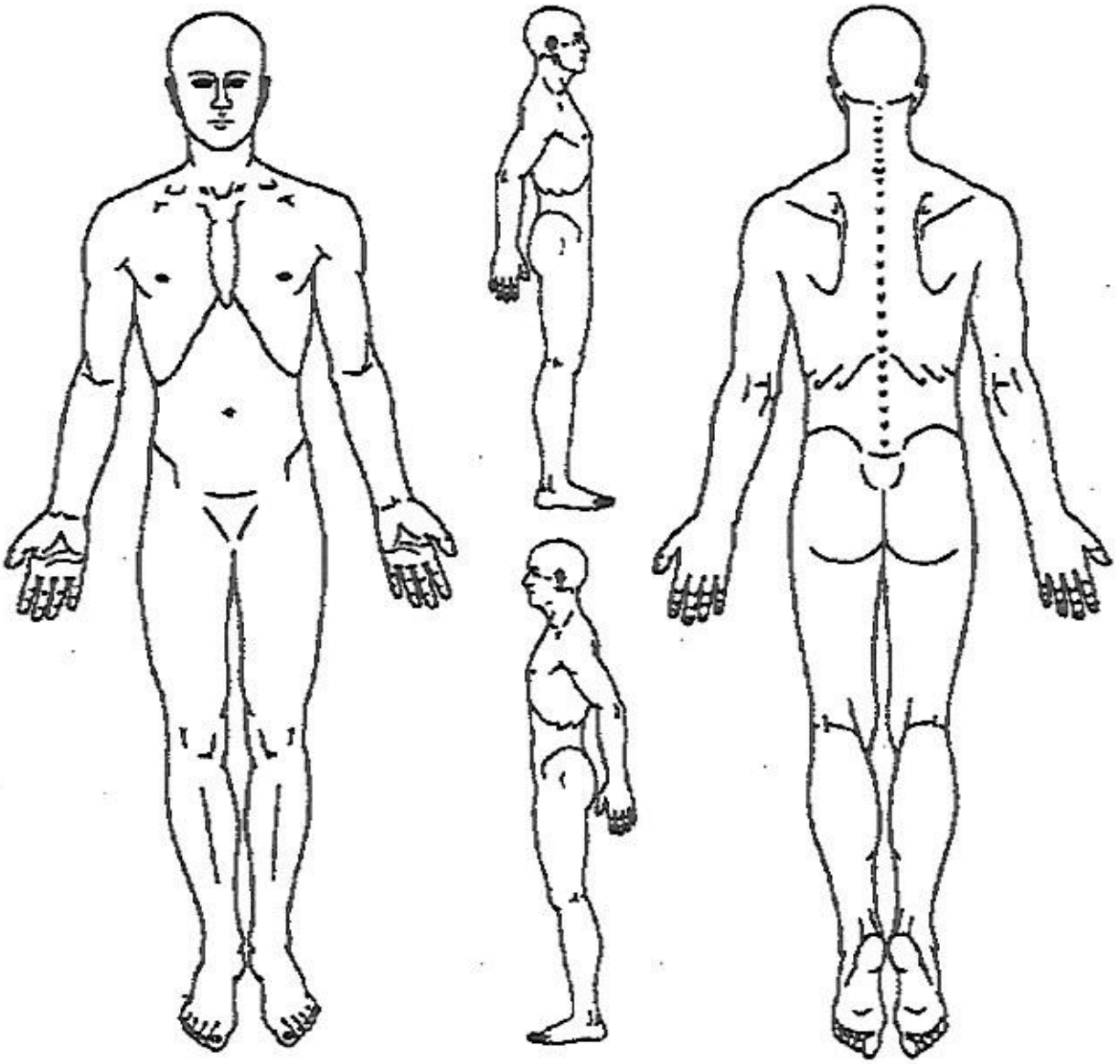
_____ _____
(Signature) (Date)

Name:_____ Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

Yarmouth Spinal Care

Cancellation & Missed Appointment Policy

The treatment that is planned for you is specific to you. It is important of you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

Therefore, we ask for at least 24 hour advance notice for cancelling or rescheduling an appointment, otherwise a $50 fee will be assessed to your account. If you are 20 minutes late to your scheduled appointment your account will be charged a $50 fee.

*All broken and cancelled appointment fees must be paid prior to scheduling another appointment.

I have read and fully understand the information provided

Patient print name:_____

Patient signature: _____Date_____

Thank you for *NOT* using perfume, cologne or scented products!

Please refrain from using these before your appointment

Many of our practice members have severe allergic reactions to scented products.

Thank you for your consideration