

# APPLICATION FOR CARE AT ITHACA FAMILY CHIROPRACTIC

## PATIENT DEMOGRAPHICS

DATE: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_  Male  Female  Non-Binary

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

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status:  Single  Married  Legally Separated  Divorced  Widowed Work Phone: \_\_\_\_\_

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

Spouse's Name \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Number of children and ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Hobbies and Interests: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

## HISTORY of COMPLAINT

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

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

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

**Primary** or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Second** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Third** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Fourth** complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes **If yes**, when: \_\_\_\_\_ by whom? \_\_\_\_\_

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

Name of Previous Chiropractor: \_\_\_\_\_  N/A

Name of Primary Care Provider: \_\_\_\_\_

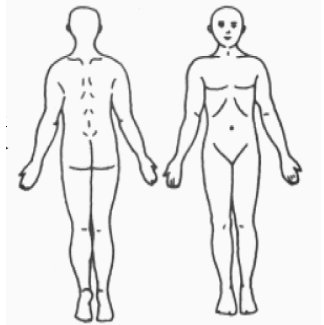
**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R** =Radiating **B** =Burning **D** =Dull **A** =Ache **N** =Numbness **S** =Sharp/Stabbing **T** =Tingling

What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_

Is your problem the result of ANY type of car or work accident?  Yes  No



Are you here for (Circle one):

1. Regular maintenance of the spine and nervous system.
2. Relief care and regular maintenance of the spine and nervous system.
3. Relief care only to get out of pain.

## SOCIAL HISTORY

**1. Smoking:**  cigars  pipe  cigarettes  smokeless tobacco How often?  Daily  Weekends  Occasionally  Never

**2. Alcoholic Beverage:** consumption occurs  Daily  Weekends  Occasionally  Never

**3. Recreational Drug use:**  Daily  Weekends  Occasionally  Never

## PAST HISTORY

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes, how many times?** \_\_\_\_\_ **When was the last episode?** \_\_\_\_\_ **How did the injury happen?** \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes, please state what type of treatment:** \_\_\_\_\_, and who provided it: \_\_\_\_\_ **How long ago?** \_\_\_\_\_ Were the results:  Favorable  Unfavorable  please explain.

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other health conditions: \_\_\_\_\_

**PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:**

HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES <input type="checkbox"/>		
SURGERIES <input type="checkbox"/>		
CHILDHOOD DISEASES <input type="checkbox"/>		
ADULT DISEASES <input type="checkbox"/>		

## ACTIVITIES OF DAILY LIVING

Please check any activities your current condition(s) is affecting:

\_\_\_ Carrying \_\_\_ Sit to Stand \_\_\_ Climb Stairs \_\_\_ Extended Computer Use  
\_\_\_ Lifting \_\_\_ Read/Concentrate \_\_\_ Getting Dressed \_\_\_ Sexual Activities  
\_\_\_ Sleep \_\_\_ Sitting \_\_\_ Standing \_\_\_ Yard Work  
\_\_\_ Walking \_\_\_ Household Chores \_\_\_ Driving \_\_\_ Other \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_ \_\_\_ Other \_\_\_\_\_

## CONDITIONS

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

\_\_\_ Headache \_\_\_ Pregnant (Now) \_\_\_ Dizziness \_\_\_ Prostate Problems \_\_\_ Ulcers  
\_\_\_ Neck Pain \_\_\_ Frequent Colds/Flu \_\_\_ Loss of Balance \_\_\_ Impotence/Sexual Dysfun. \_\_\_ Heartburn  
\_\_\_ Jaw Pain, TMJ \_\_\_ Convulsions/Epilepsy \_\_\_ Fainting \_\_\_ Digestive Problems \_\_\_ Heart Problems  
\_\_\_ Shoulder Pain \_\_\_ Tremors \_\_\_ Double Vision \_\_\_ Colon Trouble \_\_\_ High Blood Pressure  
\_\_\_ Upper Back Pain \_\_\_ Chest Pain \_\_\_ Blurred Vision \_\_\_ Diarrhea/Constipation \_\_\_ Low Blood Pressure  
\_\_\_ Mid Back Pain \_\_\_ Pain w/Cough/Sneeze \_\_\_ Ringing in Ears \_\_\_ Menopausal Problems \_\_\_ Asthma/Difficulty Breathing  
\_\_\_ Low Back Pain \_\_\_ Foot or Knee Problems \_\_\_ Hearing Loss \_\_\_ Menstrual Problems \_\_\_ Thyroid Conditions  
\_\_\_ Hip Pain \_\_\_ Sinus/Drainage Problem \_\_\_ Depression \_\_\_ PMS \_\_\_ Lung Problems  
\_\_\_ Back Curvature \_\_\_ Swollen/Painful Joints \_\_\_ Irritability \_\_\_ Bed Wetting \_\_\_ Kidney Trouble  
\_\_\_ Scoliosis \_\_\_ Skin Problems \_\_\_ Mood Changes \_\_\_ Learning Disability \_\_\_ Gall Bladder Trouble  
\_\_\_ Numb/Tingling arms, hands, fingers \_\_\_ ADD/ADHD \_\_\_ Eating Disorder \_\_\_ Liver Trouble  
\_\_\_ Numb/Tingling legs, feet, toes \_\_\_ Allergies \_\_\_ Trouble Sleeping \_\_\_ Hepatitis (A,B,C)

List Prescription & Nonprescription drugs you take: \_\_\_\_\_

## FAMILY HISTORY

Many conditions run in the family. Please list any conditions in your family relative to your condition or care in our office.



# ITHACA FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

## PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or the general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

## YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different from residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

## COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call [Brian Bartholomew](tel:6072579355) at (607) 257-9355. If [he](#) is unavailable, you may make an appointment with our receptionist to see [him](#) within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

I have received a copy of [Ithaca Family Chiropractic](#) Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

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Patient's Signature

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Date