THE SPECIFIC
CHIROPRACTIC CENTERS

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 for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The 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 subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination 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 another health care provider.

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 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

Consent to evaluate and adjust a minor child (if applicable):

I,_____ being the parent or legal gaurdian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Signature Date

Pregnancy Release:

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

Date of last menstrual cycle:_____

_____ _____
Signature Date

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Patient Information Form

The following information is needed in order to better serve you. Please complete all questions.

First Name | Middle Name | Last Name

Nick Name | SSN

Email

Address

City

State | Zip Code

Home Phone

Work Phone

Cell Phone

Gender ◯ Male ◯ Female

Birth Date

Occupation

Employer

Employer's Address

Marital Status ◯ Married ◯ Single ◯ Divorced

How did you hear about us? ◯ Self Referral ◯ Yellow Pages ◯ Screening ◯ Website ◯ Print Ad ◯ TV Ad ◯ Radio ◯ Existing Patient-

Spouse's Name | Phone Number | Occupation

Spouse's Employer | Employer's Phone Number

Employer's Address

Primary reason for visiting our office

Please mark all that apply: ☐ Job Injury ☐ Auto Injury ☐ Personal injury ☐ Home injury

☐ Been Disabled- Dates: ☐ Made a report of the injury ☐ Retained an Attorney

THE SPECIFIC
CHIROPRACTIC CENTERS

Patient Condition Form

The following information is needed in order to better serve you. Please complete all questions.

Please describe your main complaint:

Please describe how and when this problem began:

Which of the following makes the symptoms better?

- ☐ Rest
- ☐ Medication
- ☐ Sitting
- ☐ Laying down
- ☐ Standing
- ☐ Heat
- ☐ Stretching
- ☐ Ice
- ☐ Walking
- ☐ Movement
- ☐ Other:

Which of the following makes the symptoms worse?

- ☐ Rest
- ☐ Medication
- ☐ Sitting
- ☐ Laying down
- ☐ Standing
- ☐ Heat
- ☐ Stretching
- ☐ Ice
- ☐ Walking
- ☐ Movement
- ☐ Other:

Describe your pain or symptoms

- ☐ Sharp
- ☐ Achy
- ☐ Burning
- ☐ Stabbing
- ☐ Pin/Needles
- ☐ Fatigue
- ☐ Dizziness
- ☐ Dull
- ☐ Other:

How often do you experience your symptoms?

- ☐ Constant (100-75%)
- ☐ Frequent (75-50%)
- ☐ Intermittent (50-25%)
- ☐ Occasional (25-1%)

Do the symptoms radiate anywhere?

- ☐ Neck
- ☐ Shoulder
- ☐ Arm
- ☐ Fingers
- ☐ Leg
- ☐ Knee
- ☐ Ankle
- ☐ Toes

How severe are the symptoms?

- ☐ Minimal
- ☐ Mild
- ☐ Moderate
- ☐ Severe

When do you experience these symptoms?

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ All the time
- ☐ Sporadically

When was the last time you experienced this?

Is the condition: ◯ Improving ◯ Staying the same ◯ Worsening

THE SPECIFIC
CHIROPRACTIC CENTERS

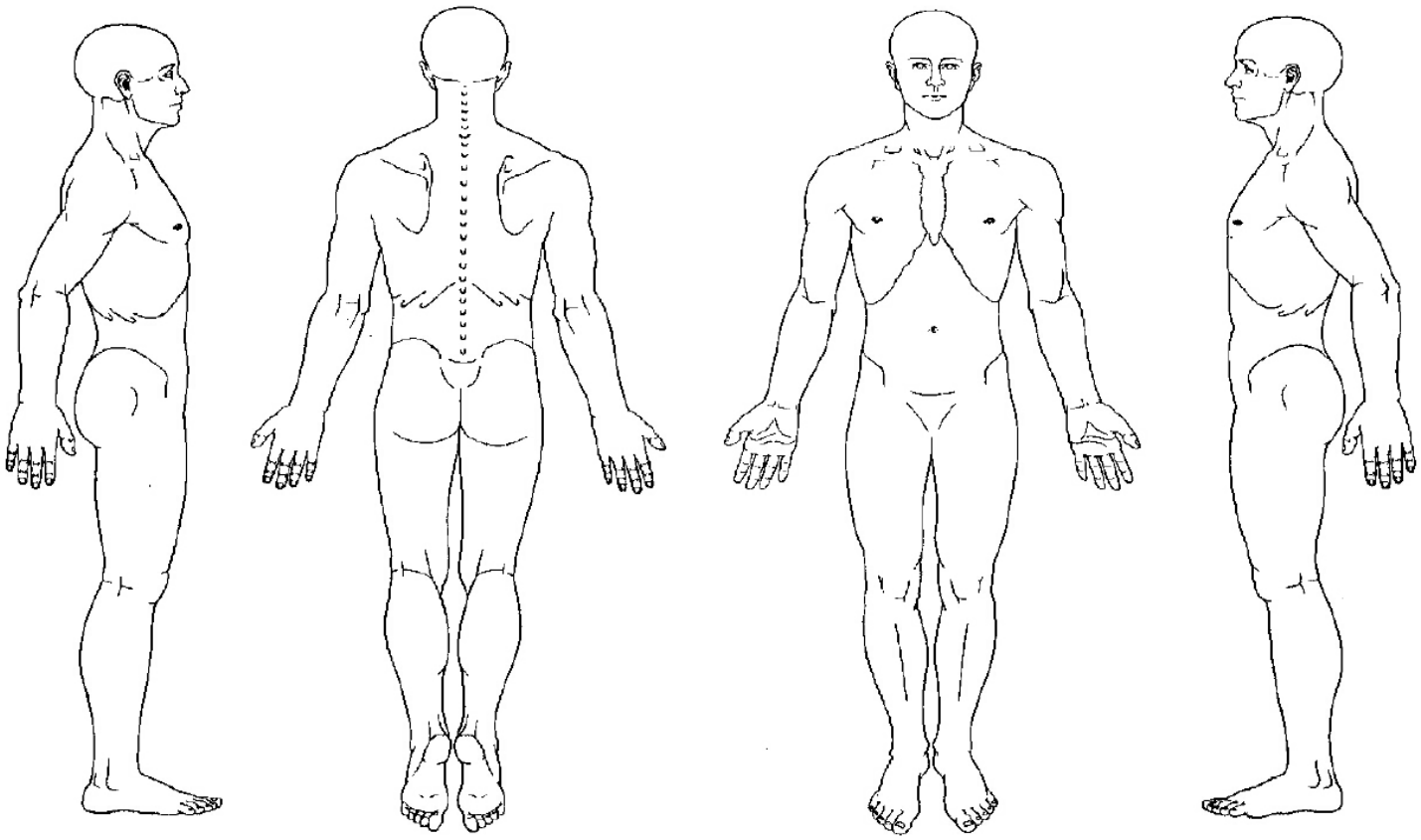
Patient Symptom Diagram

Indicate the location and type of symptom that you are experiencing

Please mark on the diagram after you have printed this document

Numbness	= = = = =	Burning	x x x x x
Pins/Needles	o o o o o	Stabbing	/ / / / /
_____	^ ^ ^ ^ ^	Aching	a a a a a

(Please describe the symptom)



Please indicate the region of pain (ie. shoulder, legs, etc.) and its severity, with 10 being incapacitated

1 2 3 4 5 6 7 8 9 10

Region:

1 2 3 4 5 6 7 8 9 10

Region:

1 2 3 4 5 6 7 8 9 10

Region:

1 2 3 4 5 6 7 8 9 10

Region:

THE SPECIFIC
CHIROPRACTIC CENTERS

Patient Health History

Please check the conditions you have or have had:

- [ ] AIDS
- [ ] Anemia
- [ ] Arthritis
- [ ] Cancer
- [ ] Chronic Fatigue
- [ ] Depression
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fibromyalgia
- [ ] High Blood Pressure
- [ ] Hypoglycemia
- [ ] Multiple Sclerosis
- [ ] Parkinson's Disease
- [ ] Polio
- [ ] Rheumatic Fever
- [ ] Rheumatiod Arthitis
- [ ] Stroke
- [ ] Tuberculosis

Please check all that apply:

General History

- [ ] Trauma/Injuries
- [ ] Height changes
- [ ] Weight changes
- [ ] Fever/Chills/Sweats
- [ ] HIV positive
- [ ] Allergies
- [ ] Anemia
- [ ] Bleeding/Bruising
- [ ] Malaise/Fatigue/Weakness

Family History

- [ ] Diabetes
- [ ] Thyroid disease
- [ ] Tuberculosis
- [ ] Kidney disease
- [ ] High blood presure
- [ ] Heart disease/Stroke
- [ ] Musculoskeletal disease
- [ ] Cancer

Endocrine System

- [ ] Heat/Cold intolerance
- [ ] Thyroid problems
- [ ] Diabetes
- [ ] Neck surgery/Irradiation
- [ ] Hormone Therapy

Eye/Ear/Nose/Throat

- [ ] Visual problems
- [ ] Eye irritation
- [ ] Pain in eyes
- [ ] Other eye problems
- [ ] Difficulty hearing/Deaf
- [ ] Ringing in ears/Dizziness
- [ ] Ear growths/Discharge
- [ ] Ear pain
- [ ] Nosebleeds
- [ ] Change in ability to smell
- [ ] Sneezing
- [ ] Nose growths/Discharge
- [ ] Nose pain
- [ ] Sinusitis
- [ ] Other nose problems
- [ ] Hoarseness
- [ ] Change in voice
- [ ] Difficulty swallowing
- [ ] Enlarged/Painful glands
- [ ] Change in ability to taste
- [ ] Dental problems
- [ ] Growths/Lesions in mouth
- [ ] Other

Gastrointestinal System

- [ ] Change in appetite
- [ ] Food intolerance
- [ ] Nausea/Vomiting
- [ ] Peptic ulcer
- [ ] Indigestion/Heartburn
- [ ] Abdominal pain
- [ ] Abdominal swelling
- [ ] Gas
- [ ] Change in stool color
- [ ] Diarrhea/Constipation
- [ ] Hernia
- [ ] Hemmorrhoids
- [ ] Gallbladder problems
- [ ] Liver disease
- [ ] Pancreatitis
- [ ] Alcohol intake

Respiratory System

- [ ] Difficulty breathing
- [ ] Cough
- [ ] Blood in sputum
- [ ] Wheezing/Asthma
- [ ] Tuberculosis/Exposure
- [ ] Pneumonia/Lung infection
- [ ] Cigarette Smoking
- [ ] Other tobacco use
- [ ] Toxic fume exposure

Examiner's notes:

THE SPECIFIC
CHIROPRACTIC CENTERS

Patient Health History

Continued

Please check all that apply:

Cardiovascular System
- ☐ Shortness of breath
- ☐ Chest discomfort/Pain
- ☐ Palpitations
- ☐ Edema/Swelling
- ☐ Fainting
- ☐ Calf pain while walking
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Cardiovascular surgeries
- ☐ Other problems

Urinary System
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Changes in color
- ☐ Difficulty starting
- ☐ Difficulty holding
- ☐ Discharrge
- ☐ Urinary tract infections
- ☐ Kidney disease
- ☐ Flank pain
- ☐ Pelvic pain
- ☐ Pelvic mass
- ☐ Other problems

Breasts
- ☐ Bumps/Lumps/Tenderness
- ☐ Dimples in breast
- ☐ Changes in color/size
- ☐ Nipple discharge
- ☐ Other problems

Reproductive System
- ☐ Genital lesions/Sores
- ☐ Genital mass/Growth/Pain
- ☐ Syphilis
- ☐ Prostate exam in last year
- ☐ Gonorrhea
- ☐ Change in sex drive
- ☐ Pain during sex
- ☐ Birth control
- ☐ Other sexual difficulties

Skin/Hair/Nails
- ☐ Change in skin temperature
- ☐ Change in skin texture
- ☐ Skin dryness/wetness
- ☐ Unusual skin coloration
- ☐ Rashes/Itching/Sores
- ☐ Skin growths
- ☐ Mole changes
- ☐ Skin cancer
- ☐ Skin pain
- ☐ Change in hair texture
- ☐ Change in hair growth/loss

Skin/Hair/Nails Continued
- ☐ Change in shape of fingernails
- ☐ Change in shape of toenails
- ☐ Change in color of nails
- ☐ Other problems

Neurological System
- ☐ Headaches
- ☐ Epileptic seizures
- ☐ Tics/Spasms
- ☐ Dizziness/Fainting
- ☐ Disturbances of sensation
- ☐ Unusual weakness
- ☐ Head trauma
- ☐ Stroke
- ☐ Other problems

Musculoskeletal System
- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Muscle wasting
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Sacroiliac pain
- ☐ Tailbone pain
- ☐ Arm problem
- ☐ Leg problem
- ☐ Fractures/Dislocations
- ☐ Sprains/Strains
- ☐ Other injuries
- ☐ Other problems

Diet/Vitamins
- ☐ Eat meals sporadically
- ☐ Unusual appetite
- ☐ Skip breakfast
- ☐ Eat between meals
- ☐ Eat late night snack
- ☐ Eat junk food
- ☐ On special diet
- ☐ Vegetarian
- ☐ Taking supplements

Implants
- ☐ Breast implants
- ☐ Cardiac pacemeaker/Etc.
- ☐ Penile implant
- ☐ Other implant

Psychological History
- ☐ Anxiety
- ☐ Depression
- ☐ Hospitalization/Therapy
- ☐ Other problems

Examiner's notes:

THE SPECIFIC
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Patient Health History

Continued

Use this space to further describe any of the conditions /symptoms listed previously or any condition other than that for which you are now consulting us:

For female patients only:

Menarche (1st period) Age Year Days in cycle:

Menstrual Cramping Pain

○ ○ ○ ○ ○ ○

0 1 2 3 4 5

Menstrual Flow:

○ ○ ○ ○

Scant Light Moderate Heavy

Duration:

- ☐ Post menopausal bleeding
- ☐ Abnormal/Painful premenstrual fluid retention
- ☐ Other female problems
- ☐ Difficult delivery
- ☐ PMS
- ☐ Hysterectomy

Examiner's notes:

THE SPECIFIC
CHIROPRACTIC CENTERS

Patient Health History

Continued

Please fill out all applicable fields:

List any traumas and their dates: (especially any head and neck injuries)

List any broken bones or dislocations:

List all surgeries and their dates:

Have you ever been unconscious, if so please explain:

List any other doctors seen, treatments, and results obtained:

THE SPECIFIC
CHIROPRACTIC CENTERS

Patient Health History

Continued

Please fill out all applicable fields:

Please list all medications you are currently taking (prescription or OTC) and the reason for taking them:

Name of medication	Reason for taking medication

THE SPECIFIC
CHIROPRACTIC CENTERS

Notice of Privacy Practices

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

In the course of your care as a patient at this clinic we may use or disclose personal and health related information about you in the following ways:

- Your health care records will be reviewed by members of this clinic's staff who are involved in the administration of patient care.
- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering service or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or, if you would like the information in a specific form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

continued on next page

THE SPECIFIC
CHIROPRACTIC CENTERS

Notice of Privacy Practices

Continued

If you have a complaint or would like further information regarding our privacy notice, our privacy practices or any aspect of our privacy activities, please contact our privacy officer:

Name:
Phone Number:
Address:

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W. Washington, D.C. 20201. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of October 1, 2004. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Please Print) Signature Date

If you are a minor, or if you are being represented by another party:

Name (Please Print) Signature Date

Description of the authority to act on behalf of the patient

THE SPECIFIC
CHIROPRACTIC CENTERS

Notice of Privacy Practices

Continued

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this clinic's "NOTICE OF PRIVACY PRACTICES".

As required by the HIPAA Privacy Regulations a staff member of this clinic has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that this clinic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective forall protected health information that it maintains.

Requests:
[ ] I wish to file a "Request for Restriction" of my Protected Health Information.

[ ] I wish to file a "Request for Alternative Communications" of my Protected Health Information.

[ ] I wish to object to the following in the "Notice of Privacy Practices":

_____

_____

_____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

_____
Signature Date

_____
Print Name

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe)

_____

_____

_____

_____

If you have any further questions or comments please feel free to contact our privacy officer.

Your Health in General

1. In general, would you say your health is:

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Fair
- ◯ Poor

2. **Compared to one year ago,** how would you rate your health in general now?

- ◯ Much better now than one year ago
- ◯ Somewhat better now than one year ago
- ◯ About the same as one year ago
- ◯ Somewhat worse now than one year ago
- ◯ Much worse now than one year ago

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at All
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	◯	◯	◯
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	◯	◯	◯
5. Lifting or carrying groceries	◯	◯	◯
6. Climbing several flights of stairs	◯	◯	◯
7. Climbing one flight of stairs	◯	◯	◯
8. Bending, kneeling, or stooping	◯	◯	◯
9. Walking more than a mile	◯	◯	◯
10. Walking several blocks	◯	◯	◯
11. Walking one block	◯	◯	◯
12. Bathing or dressing yourself	◯	◯	◯

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	Yes	No
13. Cut down the **amount of time** you spent on work or other activities.	◯	◯
14. **Accomplished less** than you would like	◯	◯
15. Were limited in the **kind** of work or other activities	◯	◯
16. Had **difficulty** performing the work or other activities (for example, it took extra effort)	◯	◯

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
17. Cut down the **amount of time** you spent on work or other activities	◯	◯
18. **Accomplished less** than you would like	◯	◯
19. Didn't do work or other activities as **carefully** as usual	◯	◯

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- ◯ Not at all
- ◯ Slightly
- ◯ Moderately
- ◯ Quite a bit
- ◯ Extremely

21. How much bodily pain have you had during the past 4 weeks?

- ◯ None
- ◯ Mild
- ◯ Very Mild
- ◯ Moderate
- ◯ Severe
- ◯ Very Severe

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ◯ Not at all
- ◯ Slightly
- ◯ Moderately
- ◯ Quite a bit
- ◯ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . .

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep?	◯	◯	◯	◯	◯	◯
24. Have you been a very nervous person?	◯	◯	◯	◯	◯	◯
25. Have you felt so down in the dumps that nothing could cheer you up?	◯	◯	◯	◯	◯	◯
26. Have you felt calm and peaceful?	◯	◯	◯	◯	◯	◯
27. Did you have a lot of energy?	◯	◯	◯	◯	◯	◯
28. Have you felt downhearted and blue?	◯	◯	◯	◯	◯	◯
29. Did you feel worn out?	◯	◯	◯	◯	◯	◯
30. Have you been a happy person?	◯	◯	◯	◯	◯	◯
31. Did you feel tired?	◯	◯	◯	◯	◯	◯

32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ◯ All of the time
- ◯ Most of the time
- ◯ Some of the time
- ◯ A little of the time
- ◯ None of the time

How TRUE or FALSE is each of the following statements for you.

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	○	○	○	○	○
34. I am as healthy as anybody I know	○	○	○	○	○
35. I expect my health to get worse	○	○	○	○	○
36. My health is excellent	○	○	○	○	○

This test was developed at RAND as part of the Medical Outcomes Survey