***Whom may we thank for referring you to this office?*** _____

# APPLICATION FOR CARE AT SOMMERS CHIROPRACTIC

Today's Date: _____ HRN: _____

## PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____Home Phone: _____Mobile Phone: _____

Cell Phone Provider: _____ Would you like to receive text reminders for your future appointments? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

## HISTORY OF COMPLAINT

***LIST YOUR HEALTH CONCERNS BELOW***

| Health Concerns: List according to severity | Rate of Severity: 1 = mild 10 = unbearable | When did this episode start? | If you had the condition before, when? | Did the problem begin with an injury? | Are symptoms constant or intermittent? |
|---|---|---|---|---|---|
| **1.** | | | | | |
| **2.** | | | | | |
| **3.** | | | | | |
| **4.** | | | | | |
| **5.** | | | | | |

**What daily activities are being restricted by your current health problems?**

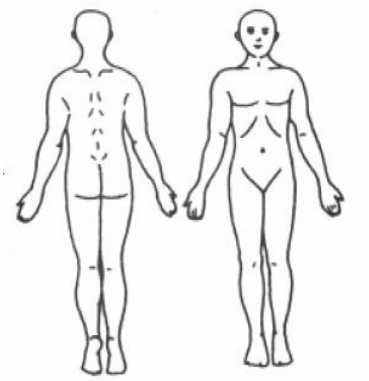
_____

_____

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
**R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____



## PAST HISTORY

***<u>CIRCLE</u> ANY CONDITION(S) YOU HAVE NOW or HAVE HAD IN THE PAST:***

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

**List all past surgical operations and the years they were performed:**

_____

_____.

**List all over-the-counter and prescription medications you are currently taking:**

_____

_____.

**Have you ever seen other doctors for the conditions you listed on the first page?** ☐ Yes ☐ No

Chiropractor? _____ Medical Doctor? _____ Other _____

**If yes, who and when?** _____

**Are your health concerns the result of ANY type of accident?** ☐ Yes ☐ No

**Identify any other injury(s) to your spine, minor or major, that the doctor should know about:**

_____

_____

**Have you ever been involved in an auto accident?** ☐ Yes ☐ No **If yes, when?** _____

**Have you ever been knocked unconscious?** ☐ Yes ☐ No **If yes, when?** _____

**Have you ever fractured a bone?** ☐ Yes ☐ No **If yes, when?** _____

## SOCIAL HISTORY

**1. Smoking**: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
**2. Exercise:** → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
**3. How does your present problem affect the following:** Hobbies / Recreational Activities / Exercise Regime:

_____

## FAMILY HISTORY:

**1.** Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
**If yes whom**: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s)
☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
**2. Any** other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

I hereby authorize payment to be made directly to Sommers Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Sommers Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____
Doctor's Signature Date Form Reviewed

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| ACTIVITIES: | EFFECT: | | | |
|---|---|---|---|---|
| Carry Children/Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sit to Stand | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Climb Stairs | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Pet Care | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Extended Computer Use | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Lift Children/Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Read/Concentrate | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Getting Dressed | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Shaving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sexual Activities | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sleep | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static Sitting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Yard work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Washing/Bathing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sweeping/Vacuuming | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Dishes | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Laundry | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Garbage | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Other: _____ | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |

**Patient signature: _____ Today's Date: __/__/__**

*Continued on next page*

# REVIEW OF SYSTEMS

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

| | | | | |
|---|---|---|---|---|
| ____ Headache | ____ Pregnancy (Now) | ____ Dizziness | ____ Prostate Problems | ____ Ulcers |
| ____ Neck Pain | ____ Frequent Colds/Flu | ____ Loss of Balance | ____ Sexual Dysfunction | ____ Heartburn |
| ____ Jaw Pain, TMJ | ____ Convulsions/Epilepsy | ____ Fainting | ____ Digestive Problems | ____ Heart Problem |
| ____ 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 |
| ____ Low Back Pain | ____ Foot or Knee Problems | ____ Hearing Loss | ____ Menstrual Problems | ____ Difficulty Breathing |
| ____ Hip Pain | ____ Sinus/Drainage Problem | ____ Depression | ____ PMS | ____ Lung Problems |
| ____ Back Curvature | ____ Swollen/Painful Joints | ____ Irritable | ____ 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) |

**QUADRUPLE VISUAL ANALOGUE SCALE**

Patient Name _____ Date _____

**Please read carefully:**

**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

**Example:**

| | Headache | | | | Neck | | | | Low Back | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | | | | | | | | | | | **worst possible pain** |
| **0** | **1** | **(2)** | **3** | **4** | **(5)** | **6** | **7** | **(8)** | **9** | **10** | |

---

**1 – What is your pain RIGHT NOW?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | | | | | | | | | | | **worst possible pain** |
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | |

**2 – What is your TYPICAL or AVERAGE pain?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | | | | | | | | | | | **worst possible pain** |
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | |

**3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | | | | | | | | | | | **worst possible pain** |
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | |

**4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No pain** | | | | | | | | | | | **worst possible pain** |
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | |

**OTHER COMMENTS:**

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

# 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. I have been informed that a Chiropractic Student Intern may be assigned to perform some part of my clinical care at this office and that the intern is not yet a licensed Doctor of Chiropractic. I understand that the Intern is working under the authority and auspices of this office.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Sommers 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.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

**REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY** → *please read carefully and 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 ____-____-____ (Date)

☐ 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.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

# SOMMERS 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 **P**ersonal **H**ealth **I**nformation. 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 area 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 eminent threat to the health or safety of a person or 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 apprize 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 than 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 Victoria Sommers at (802) 497-2938. If she is unavailable, you may make an appointment with our receptionist to see her 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

*Patient initials:* **_____-retaining *page 1 of 2***

## *SOMMERS CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…*

I have received a copy of Sommers 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 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.

| Patient's Name | DOB | HR# |
|---|---|---|

| Patient's Signature | Date |
|---|---|

| Witness | Date |
|---|---|