

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: \_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance:  Yes  No Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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?
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1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

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

\_\_\_\_\_

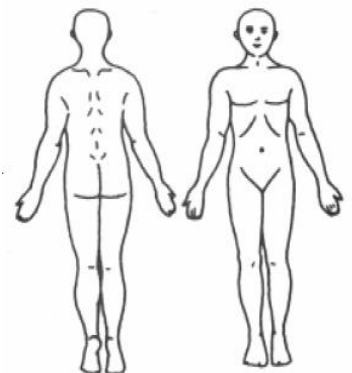
\_\_\_\_\_

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

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

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

What makes them feel worse? \_\_\_\_\_



**PAST HISTORY**

**CIRCLE 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

## 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	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> 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**

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

**QUADRUPLE VISUAL ANALOGUE SCALE**

Patient Name \_\_\_\_\_

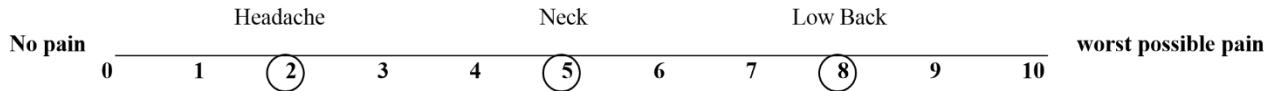
Date \_\_\_\_\_

**Please read carefully:**

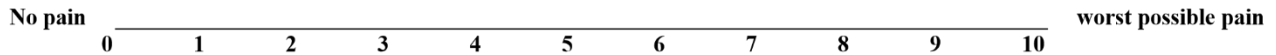
**Instructions:** Please circle the number that best describes the question being asked.

**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.

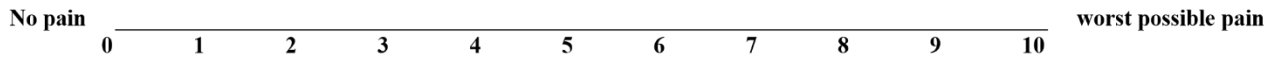
**Example:**



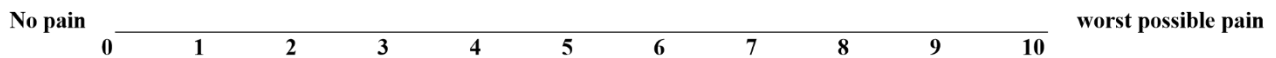
**1 – What is your pain RIGHT NOW?**



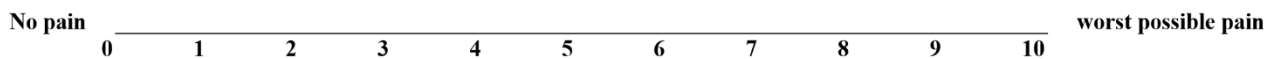
**2 – What is your TYPICAL or AVERAGE pain?**



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



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



**OTHER COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_

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.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
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.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
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 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 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 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 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