

NEW PATIENT INFORMATION

Patient Name: _____ Today's Date: _____

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

Social Security No. _____ Date of Birth: _____ Home Phone: _____

Cell Phone: _____ Cell Carrier: (to enable texting) _____

Employer: _____ Work Phone: _____ E-Mail: _____

Primary Care Physician: _____ ☐ Married ☐ Single Children # _____

Any Previous Chiropractic Care? ☐ Yes ☐ No If yes, Who? _____

INSURANCE INFORMATION

Primary Insurance:

Insurance Company: _____

Policy ID#: _____ Group Plan #: _____

Insured Name: _____ DOB: _____ Social Security #: _____

Insured's Employer: _____ Relationship to Insured: _____

Secondary Insurance: (if applicable)

Insurance Company: _____ Address: _____

Policy ID#: _____ Group Plan #: _____

Insured Name: _____ DOB: _____ Social Security #: _____

Insured's Employer: _____ Relationship to Insured: _____

AUTO INSURANCE INFORMATION
(IF APPLICABLE)

Auto Insurance Co.: _____ Phone: _____

Insurance Co. Address: _____

Policy Holder Name & Address (if other than yourself): _____

Relationship to Patient: _____ Did you report your accident? ☐ Yes ☐ No

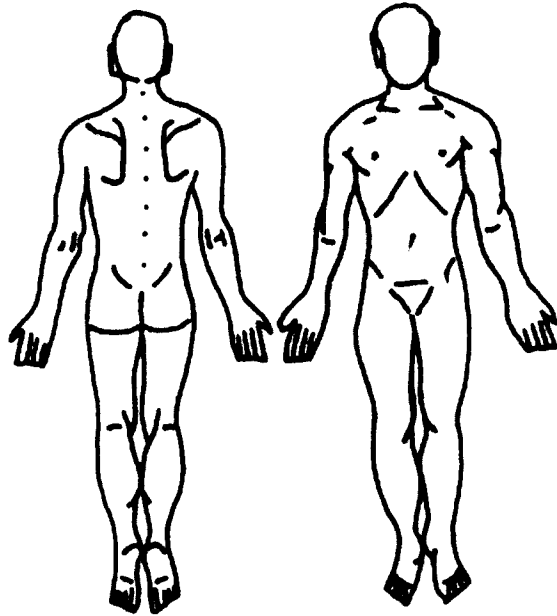
Policy# _____ Claim# _____ Date of Accident: _____

Insurance Adjuster Handling Claim: _____ Phone/Ext: _____

Patient/Guardian Signature: _____ Date: _____

Name: _____**Date:** _____**Rate your complaint** (10 most severe)

1 2 3 4 5 6 7 8 9 10

Mark areas of discomfort or pain:

If yes, Where? _____

Mark all associated with your discomfort:

- | | | | |
|-------------------------------------|---|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Burning | <input type="checkbox"/> Sharp Pain |
| <input type="checkbox"/> Dull Ache | <input type="checkbox"/> Weakness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Constant | <input type="checkbox"/> Intermittent |

General difficulties:

- | | | | | |
|---|---|---|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Sleep loss | <input type="checkbox"/> Walking | <input type="checkbox"/> Driving | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Standing | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Tying shoes | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Combing hair | <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Washing dishes | | |
| <input type="checkbox"/> Rolling over while lying | <input type="checkbox"/> Rising from sitting/lying position | | | |

☐ Male ☐ Female Height _____ Weight _____

Purpose of appointment? _____

When did this condition begin? _____

Have you seen another doctor (MD/DC/DO) for condition? ☐ Yes ☐ No

If Yes, When and Who? _____

Any ☐ X-rays, ☐ CT Scans, ☐ MRI's for condition? ☐ Yes ☐ NoSurgeries: ☐ Yes ☐ No If Yes, When/What? _____

Medications: _____

History:

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid (hyper/hypo) | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema/Psoriasis | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental disorder | |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis | |

Dietary Intake:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Red meat | <input type="checkbox"/> Dairy |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Soda |
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Tea |
| <input type="checkbox"/> White sugar | <input type="checkbox"/> Artificial sweeteners |
| <input type="checkbox"/> White flour | |

Check all that apply:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor/excessive appetite | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Confusion | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Shortness breath |
| <input type="checkbox"/> Clicking/Locking Jaw | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Congestive Heart |
| <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Fever | <input type="checkbox"/> Bloating | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Arm/Leg discomfort | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Gall stones | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> High/low blood pressure |
| <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Black/Bloody stool | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Polyps/Diverticulum | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing difficulties | <input type="checkbox"/> Weight trouble | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Discolored/smelly urine | <input type="checkbox"/> Ankle swelling |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Varicose veins |

Patient or Guardian Signature_____
Date**Females:**

Last period? _____

Are you pregnant? ☐ Yes ☐ No

If yes, how many weeks? _____

How many children? _____

History cesarean section? ☐ Yes ☐ No

COPENHAGEN NECK FUNCTIONAL DISABILITY SCALE

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY ACTIVITIES. IN RESPONSE TO EACH QUESTION, PLEASE MARK THE ONE BOX THAT APPLIES TO YOU.

	Yes	OCCASIONALLY	No
1. CAN YOU SLEEP AT NIGHT WITHOUT NECK PAIN INTERFERING?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CAN YOU MANAGE DAILY ACTIVITIES WITHOUT NECK PAIN REDUCING ACTIVITY LEVELS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CAN YOU MANAGE DAILY ACTIVITIES WITHOUT HELP FROM OTHERS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CAN YOU MANAGE PUTTING YOUR CLOTHES ON IN THE MORNING WITHOUT TAKING MORE TIME THAN USUAL?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. CAN YOU BEND OVER THE SINK TO BRUSH YOUR TEETH WITHOUT GETTING NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. DO YOU SPEND MORE TIME THAN USUAL AT HOME BECAUSE OF YOUR NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU PREVENTED FROM LIFTING OBJECTS WEIGHING 5-10 POUNDS DUE TO NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU REDUCED YOUR READING ACTIVITY DUE TO NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. HAVE YOU BEEN BOTHERED BY HEADACHES DURING THE TIME YOU HAVE HAD NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. DO YOU FEEL THAT YOUR ABILITY TO CONCENTRATE IS REDUCED DUE TO NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. ARE YOU PREVENTED FROM PARTICIPATING IN YOUR USUAL LEISURE TIME ACTIVITIES DUE TO NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. DO YOU REMAIN IN BED LONGER THAN USUAL DUE TO NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. DO YOU FEEL NECK PAIN HAS INFLUENCED YOUR EMOTIONAL RELATIONSHIP WITH YOUR FAMILY?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. HAVE YOU HAD TO GIVE UP SOCIAL CONTACT WITH OTHER PEOPLE DURING THE PAST TWO WEEKS DUE TO NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. DO YOU FEEL THAT NECK PAIN WILL INFLUENCE YOUR FUTURE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT NAME _____

DATE _____

Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____
 EXAMINER _____ DATE _____ Score _____ [72]

NOTICE OF PRIVACY PRACTICES

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

This Chiropractic Practice, Spine One Chiropractic Center, in accordance with the federal Privacy Rule, 45 CFR parts 160 & 164 (the Privacy Rule) and applicable state law, is committed to maintaining the privacy of your protected health information (PHI). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This notice explains how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

The practice, in accordance with this notice and without asking your express consent or authorization may use and disclose your PHI for the purpose of:

- A. **TREATMENT** – For coordination, planning and management of your health care.
- B. **PAYMENT** – To get paid for services directly through you, billing service, and insurance company or health plans.
- C. **HEALTHCARE OPERATIONS** – To evaluate performance of the Practice's personnel providing care to you.
- D. **ADVISE OF APPOINTMENT SERVICES** – Following appointment reminders may be used by the practice:
 - 1. Postcards
 - 2. Telephoning home
 - 3. Email
 - 4. Telephoning cell phone and/or texting
- E. **DIRECTORY/SIGN-IN LOG** – Practice maintains a sign-in log at the reception area where staff can readily see. Others seeking services/care at the Practice may see this information.
- F. **FAMILY/FRIENDS** – Disclose PHI to family member, other relative, friend or other person identified by you for involvement in care or payment of care.
- G. **USE OF NAME** – Your name may be used in a verbal or written manner when requesting information over the phone or between staff members or when using a social media that you have agreed to by "liking or following", such as FACEBOOK or TWITTER. This in no way implies your PHI has been disclosed.
- H. **EMAIL/TEXTING** - You may be contacted thru email and/or text to convey information/correspondence regarding you and this practice.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

- A. **DE-IDENTIFIED INFORMATION** – Disclose PHI, for sake of your care, which cannot identify you.
- B. **BUSINESS ASSOCIATE (BA)** – BA includes entity that assists the Practice in some essential function.
- C. **TCPA** - Telephone Consumer Protection Act - our office and/or our agents may contact you by telephone, including wireless numbers by call or text, which could result in charges from your wireless carrier. Methods may include pre-recorded voice messages or an automatic dialing device. We may also contact through email.
- D. **PERSONAL REPRESENTATIVE** – A person who has the authority to represent your decisions.
- E. **EMERGENCY SITUATIONS**
- F. **PUBLIC HEALTH EMERGENCY** – To prevent or control disease.
- G. **ABUSE, NEGLECT OR DOMESTIC VIOLENCE**
- H. **HEALTH OVERSIGHT ACTIVITIES** – PHI for criminal investigation, disciplinary actions or relating to community's health care system.
- I. **JUDICIAL & ADMINISTRATING PROCEEDING** – For court order or lawfully issued subpoena.
- J. **LAW ENFORCEMENT PURPOSES** – Use PHI when authorized to Law Enforcement official.
- K. **CORONER OR MEDICAL EXAMINER**
- K. **ORGAN, EYE, OR TISSUE DONATION** – May disclose your PHI if you are a tissue or organ donor.
- L. **RESEARCH** – May disclose PHI subject to legal requirements if the Practice is involved in research.
- M. **AVERT THREAT TO HEALTH AND SAFETY** – Disclose PHI necessary to prevent serious threat to health or safety.
- N. **FINANCIAL HARDSHIP** - Financial agreements are available for those who qualify at time of service & who are unable to meet their total financial obligation.
- O. **SPECIALIZED GOVERNMENT FUNCTION** – Use PHI, authorized by law, for military and veteran activity.
- P. **WORKERS COMPENSATION OR MVA**
- Q. **NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES**
- R. **MILITARY AND VETERANS** – Disclose PHI, if member of armed forces, required by military command authorities.
- S. **TIME OF SERVICE PAYMENT** – All patients are eligible for a discount if payment for services rendered are made at time of service. If payment is not made at the time of service the patient is responsible for full charges incurred.

PRACTICE REQUIREMENTS

- A. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- B. Maybe required by State Law to maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal Law.
- C. Is required to abide by the terms of this Privacy notice.
- D. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- E. Will distribute any revised Privacy Notice to you prior to implementation.
- F. Will not retaliate against you for filing a complaint.

YOUR RIGHTS

- A. Revoke any authorization or consent given to the Practice in a written request.
- B. Request restrictions on certain uses & disclosures of your PHI in written form.
- C. Inspect & copy your PHI. Practice can charge fee for copying, mailing or other supplies associated with request.
- D. Amend your PHI as provided by federal Law. You must submit written request to the Practices Privacy Officer (PPO).
- E. Receive accounting disclosures or PHI as provided by the Federal Law. Time period may be no longer than six (6) years and may not include dates before April 14, 2003. The first list within a 12-month period is free. Practice may charge for additional lists.
- F. Receive paper copy of Privacy Notice from Practice.
- G. Complain to Practice or Secretary of HHS if you believe your rights have been violated.

To file a complaint with the Practice or to obtain more information about your rights contact the Practice's Privacy Officer.

Name: Christi Murphy

Address: 300 Philadelphia Ave., Egg Harbor, NJ 08215

Telephone: 888.888.9260

AUTHORIZATION

Uses and/or disclosures other than those described above will be made only with your written request.

This notice is in effect as of 4.15.03 (Revised 8/19/2020)