

Full Potential Chiropractic

Please complete all questions.

Name:		Date:	
Address:		City/State/ZIP:	
Home Phone:	Work Phone:	Cell Phone:	
Birth date:	Age:	Social Security #:	
Marital Status:	M W D S	E-mail address:	
Your Employer:		Occupation:	
Spouse's Name:		Spouse's Employer:	
Children's Names and Ages:			
Favorite Hobbies or Interests:			
Emergency Contact Person and Phone #:			

Current health concerns/reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

Who may we thank for referring you? _____

Have you had same or similar problem(s) before? _____

If so, for how long? _____

Is this the result of an auto or work injury? _____ If so, when? _____

Father, mother, brother, sister, children with similar problems? _____ If so, who? _____

Other doctors you have seen for this problem: _____

Surgeries you have had: _____

Medications you currently take: _____

Is there any chance you are pregnant? _____

Have you ever been diagnosed with cancer? _____ If so, what kind? _____

Do you have health insurance? _____ Name of company: _____

Policy # _____ Policy holder _____

(over)

Stress Test

The following areas of stress can cause misaligned vertebrae (Subluxation).

Which of these stresses do you recognize?

Please circle when you experienced these stresses:

Child=C, Teenager=T, Adult=A

Physical/ Emotional/ Chemical Stress:

Comments:

Birth Trauma	C			
Slips or Falls	C	T	A	
Automobile Accidents	C	T	A	
Sports Injuries	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	
Extensive Computer Work		T	A	
Sleeping on Stomach		T	A	
Sitting on a Wallet		T	A	
Carrying a Heavy Purse/ Bookbag/ Child		T	A	
Repetitive Lifting/ Bending		T	A	
Driving for Many Hours		T	A	
Continuous Hours Sitting/ Standing		T	A	
Children Stress		T	A	
Career Stress			A	
Relationship Stress	C	T	A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker/ 2 nd Hand Smoke	C	T	A	Amount: _____
Poor Diet/ Excessive Sugar	C	T	A	Amount: _____
Caffeine	C	T	A	Amount: _____
Artificial Sweeteners	C	T	A	
Prescription Drugs	C	T	A	
Over The Counter Drugs (eg, Tylenol, Motrin, etc.)	C	T	A	

Which do you feel are your primary stresses? _____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

The following are policies of Dr. Angela Gambale O'Brien and Dr. Jamie Engel and will be implemented unless patients notify her in writing that they do not wish to participate:

OPEN ADJUSTING ENVIRONMENT:

It is the practice of Dr's Angela Gambale O'Brien and Jamie Engel to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being in the same adjusting area at the same time. Patients may be within sight of one another and some ongoing routine details of care may be discussed within earshot of other patients and staff. The environment is used for ongoing care and is NOT the environment used for taking patients histories or performing examinations. These procedures are complete in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matter related in an "open adjusting" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure.

It is our desire for our staff to use the name, address, e-mail address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and important office information such as office hour changes and cancellations.

We would like to use your name, signature, photographs and/or radiographs on our "Thank You Board" , our "Patient of the Week" , and our "Kids Picture Wall" . Please let us know if you wish not to participate.

It is our desire for our staff to use your name and/or signature on our sign-in sheets in order to verify your office visit.

As a courtesy to our patients, if you miss an appointment, it is our policy to call your home or cell phone to reschedule your appointment time. If you are not available, we will leave you a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment.

NOTICE OF PRIVACY PRACTICES, CONTINUED:

The use of this information is intended to make your experience with our office more efficient, productive, and to further enhance your access to quality chiropractic care. If you choose to not authorize the use of this information, your decision will have no adverse affect on your care from Dr's Angela Gambale O'Brien and Jamie Engel or on your relationship with our staff.

Dr's Angela Gambale O'Brien and Jamie Engel reserves the right to change this notice and to make the revised Privacy Notice effective for all your protected health information that it contains. Each time you are a patient at Dr's Angela Gambale O'Brien and Jamie Engel's office we will offer you a copy of current notice in effect.

EFFECTIVE DATE:

This notice is in effect as of September 23, 2008.

ACKNOWLEDGMENT:

I acknowledge that I have been offered to review a copy of the Notice if Privacy Practices.

Name of Individual (print)

Signature of Individual

Date

If Patient is a Minor,

Signature of Individual

Relationship

Date

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.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alterations 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.

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.

We do not offer diagnosis or treatment of any disease. However, during the course of a chiropractic spinal examination, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend that you seek the services of another health care provider.

Our practice objective is to eliminate 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)

All my questions regarding the doctor's objective pertaining to chiropractic care at Full Potential Chiropractic have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child

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

Full Potential Chiropractic
186 Burrill Street
Swampscott, Ma 01907
(781) - 593 -2388

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay by check directly to this office for the professional or chiropractic expense benefits allowable, **otherwise** payable to me under my current insurance policy as payment towards the total charges for professional services rendered by this office.

A photocopy of this assignment shall be considered as effective and valid as the original.

RELEASE INFORMATION

I authorize this office to release any medical information pertinent to my care to my insurance company, adjuster, and/or attorney involved in this case; and hereby this office of any consequence thereof.

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this office including my insurance deductible, co-payment and any services rejected by my insurance company.

PATIENT SIGNATURE: _____

DATE: _____