

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

*Please complete all questions*

<b>Name:</b>		<b>Date:</b>
<b>Address:</b>		<b>City/State/Zip:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell:</b>
<b>Birth date:</b>	<b>Age:</b>	<b>Social Security Number:</b>
<b>Marital Status:</b> M    W    D    S	<b>Email address:</b>	
<b>Your Employer:</b>	<b>Occupation:</b>	
<b>Spouse's Name:</b>	<b>Spouse's Employer:</b>	
<b>Children's Names and Ages:</b>		
<b>Favorite Hobbies or Interests:</b>		
<b>Emergency Contact Person and Phone Number:</b>		

**Current health concerns/reasons for consulting out office:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Who may we thank for referring you to our office?** \_\_\_\_\_

**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:** \_\_\_\_\_

**Medication 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 insurance provider:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_ **Policy Holder:** \_\_\_\_\_

## 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/ Backpack/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		T	A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker/2 <sup>nd</sup> 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.

\_\_\_\_\_  
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 Drs. 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 other than the date and time of your scheduled appointment.

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 Drs. Angela Gambale O'Brien and Jamie Engel or on your relationship with our staff.

Drs 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 Drs. 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 Parent/Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
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** is 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** 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** is 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, we will make you aware you during the course of a chiropractic spinal examination if we encounter non-chiropractic or unusual findings. If you desire advise, 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 in 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 of Individual

\_\_\_\_\_  
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 of acceptance and hereby grant permission for my child to receive care.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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**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 I hereby release 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

**IF PATIENT IS A MINOR:**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

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**PATIENT PREGNANCY DISCLAIMER**

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In doing so, I release the doctor/clinic from the responsibility for potential damage arising from this procedure.

Check the appropriate box and sign below.

At the present time:

- I am certain that I am not pregnant.
- It is possible that I could be pregnant.
- I am pregnant.

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Patient Signature

Date

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Witness

NOTE: Female patients should be questioned as to the last date of their menstrual cycle and the 10-day rule should always be applied for protection of the patient and possibly the fetus.