Tranquility spinal care LLC

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Today's Date:____________________
Who can we *thank* for your referral?________________________________

MEMBER INFORMATION

Name: ____
What do you prefer to be called? ______________
Address:______________________________________
City:____
State:__________Zip:__________
Phone Numbers:
Home:________________Cell:______________
Work:________________ Other: ____________
Email Address:_________________________________
Gender: Male or Female
Marital Status: **S M W D**
Date of Birth:____________________
Social Security Number:___________________
Spouse's Name:___________________________
Number of Children:____________
Ages of Children:____________

Occupation:_______________________________
Employer's Name:__________________________
Employer's Address:________________________
Are you a Medicare recipient?

Yes ☐ No ☐

EMERGENCY INFORMATION

Emergency Contact
Name:____
Relationship: __________Phone ______________

OTHER HEALTHCARE PROVIDERS

Family Physician
Name:____
Address:______________________________

Medical Specialists
Name:____
Specialty:____________________________
Reason for Care:______________________

Name:____
Specialty: ____________________________
Reason for Care:______________________

Name:____
Specialty:____________________________
Reason for Care:______________________

Dentist
Name:____

Naturopath
Name:____

Physical Therapist
Name:____

Massage Therapist
Name:____

Release of information authorized:

I authorize Tranquility Spinal Care to communicate with the above mentioned healthcare providers regarding my health and chiropractic care so that all my providers can work together for my best health.

Member Signature:____________________________
Date:______________

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.
The HIPPA (Health Insurance Portability and Accountability) Act requires us to maintain the privacy of your health information, and to inform you about our privacy practices. This law was written to protect the confidentiality of your health information. You may request a copy of our privacy notice at any time by simply asking the front office staff or your doctor.

HOW YOUR HEALTH INFORMATION MAY BE USED:

To provide treatment

Within our office your health information will be used to provide you the best care and services possible. This may include communication between you and office personnel to optimize scheduling and completion of clinical procedures. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.

To conduct health care operations

Your doctor may discuss your case and/or x-rays with another doctor, student, intern, associate, as well as business/clinical employees of the practice. This is for the sole purpose of training and education. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may also be reviewed during the routine certification, licensing, and credentialing processes.

To obtain payment

Your health information may be included with paperwork submitted for the purpose of collecting payment for services provided to you in this office.

In member reminders

Because we believe regular care is important to your health, we will remind you of scheduled appointments, or the need for you to contact our office. These reminders may include but are not limited to phone calls, postcards, newsletters, flyers, email, or voice messages.

To fulfill public health/national security obligations

We may be required to disclose your health information to report problems related to public health or national security such as disease/infection exposure to prevent or control disease, injury, and/or disability to others

As required by law

We may be required by law to disclose your health information to the proper authorities for the purpose of law enforcement, such as if you are the victim of a crime, abuse, neglect, domestic violence, or other criminal acts.

To designated family/emergency contacts/caregivers

We may share your health information with a family member or other person responsible for your care in the event of an emergency. In such emergent situations, if you are unable to communicate your wishes, we will use our best judgment when sharing your health information with others involved with your care.

Other than is stated above, or where federal, state, or local law requires, we will not disclose your health information other than with your written authorization. You may revoke this authorization in writing at any time.

Your Privacy Rights As A Practice Member:

Confidential communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information to you privately, with/without family or caregivers present, or through sealed mail communications. We will make every effort to honor all reasonable requests.

Access to your health information

You have the right to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you are the legal guardian of a minor, you have this same right regarding their information. If you would like to have a copy of your records, please let us know in writing. This service may require a small fee, and a reasonable amount of time to complete.

Amendment of your health information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. Your request must be in writing, and include and explanation of why the information should be amended. The request may be denied under certain circumstances including, but not limited to the following; the information was not originally created by our office, is not part of our records, or if the records have been requested to be sealed and delivered to authorities for review.

Restrictions

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these requests, but if we do, we will abide by our agreement (except in the case of an emergency). These requests must be in writing. You may discuss this further with the front office staff or your doctor.
You have the right to request a copy of our office's notice of privacy practices at any time. We are required, by law, to maintain the privacy of your health information and to provide you and/or your caregiver our privacy practices information. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of this policy, and practice members will be notified in the event of any such changes.
In the case that you believe your privacy rights have been compromised, you have the right to express your concerns with us or with the Secretary of Health and Human Services.

Thank you for taking the time to review how we carefully protect your private health information. If you have any questions or concerns, please do not hesitate in asking for clarification. We appreciate that you acknowledge having read through, understand, and received this policy.

Practice Member Acknowledgement:

Member Name:____
Member Signature:______________________________Date:________

If you are a minor, or if another party is representing you, this notice must be acknowledged by the party authorized to act on your behalf.

Name of Representative:____
Relationship to Member:____
Representative Signature:________________________ Date:________

Tranquility spinal care LLC

TERMS OF ACCEPTANCE

When a person seeks chiropractic health care, and we accept a practice member for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each member understand both the objective and the method that will be used to attain it. This understanding will prevent any confusion or disappointment.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column, which causes alteration 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: An adjustment is the specific application of forces to remove a vertebral subluxation found in the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________, have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

X______________________________ ______________
(member signature) (date)

Member Name: ____________________

Health Questionnaire

What level of wellness are you seeking? ☐ Symptom-Free ☐ Optimum health

Are you as healthy today as you were 5 years ago? ☐ Yes ☐ No What is the reason for this?

____

____

Will you be as healthy 5 years from now as you are today? ☐ Yes ☐ No What is the reason for this?

____

____

What can you do to improve your situation?

____

____

Current Health Condition

What is your primary objective for consulting our office?

____

____

When did this condition begin? (*please be as specific as possible*) ____________________

Do you know what brought this condition on? (i.e. accident, fall, etc.)

____

____

How often do you experience the symptoms? ☐Constant ☐Frequent ☐Intermittent ☐Occasional ☐Rarely

What makes the symptoms worse? (i.e. standing, sitting, heat, etc.) ____________________

What relieves the symptoms? (i.e. nothing, ice, heat, walking, sitting, etc.) ____________________

Does coughing or sneezing aggravate this condition? ☐ Yes ☐ No

Describe the pain ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Numb Other: __________

Do you notice the pain more at a particular time of the day? ____________________

On a scale of 1-10, 10 being the worst, please rate your pain:

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

On a scale of 1-10, 10 being the worst, please rate your quality of life:

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How is this issue affecting your way of life? Does it prevent you from doing anything?

____

____

Helping this issue would increase my quality of life by:

10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please use the back of this form to provide any additional information that you would like the Doctor to know.

Member Name: ____________________

Secondary Complaints

Please list any other areas of complaint, the severity, and when each began:

Complaint: ____________________ Rate the pain (1-10): _____ Beginning Date: ____________________

Complaint: ____________________ Rate the pain (1-10): _____ Beginning Date: ____________________

HEALTH HISTORY

The following list of conditions may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems constitute an important component of your health history and assist the doctor with your care or referral for appropriate care.

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Herpes
- ☐ HIV Positive
- ☐ Hypertension
- ☐ Influenza
- ☐ Measles
- ☐ Mental Disorder
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Infection
- ☐ Whooping Cough

Other: ____________

Please check if you have had any of these symptoms in the past six months.

Musculo-Skeletal System:
- ☐ Neck Pain
- ☐ Pain between shoulders
- ☐ Arm Pain
- ☐ Low Back Pain
- ☐ Knee/Leg Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw

Nervous System:
- ☐ Anxiety/Panic Attack
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Pins/Needles
- ☐ Cold Extremities

Male Reproductive System:
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

Female Reproductive System:
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Genital Herpes
- ☐ Pregnant: ☐ Yes ☐ No
- ☐ Date of last period: ________

Cardio-Vascular System:
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ High/Low Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Other Heart Condition
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT System:
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ History of Throat Infection
- ☐ History of Ear Infection
- ☐ Tinnitis
- ☐ Hearing Difficulty

Gastro-Intestinal System:
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver/Gall Bladder Dysfunction
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

Genito-Urinary System:
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Odiferous Urination
- ☐ Discolored Urine

General:
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headache

Member Name: ______________________

OCCUPATIONAL INFORMATION

The information provided below will help the doctor evaluate your present condition, and he may offer additional advice based on the information you provide.

Work involves:

☐ Bending ☐ Stooping ☐ Twisting ☐ Turning ☐ Sitting

Standing: Length of time: ___________ Lifting: Amount of weight: ___________

How long do you speak on the phone each day? ___________ ☐ Traditional receiver ☐ Headset

Physical Activity: ☐ Sedentary ☐ Light manual labor ☐ Heavy manual labor

Do you believe that your condition was caused by your work? ______________________________________

Do your work activities aggravate your present condition? ______________________________________

HEALTH/LIFESTYLE HABITS

This information will allow the doctor to assess choice that you make in several areas of your life. These choices may, or may not, be contributing to your present condition, but they are an integral part of your overall health.

Sleep:

Hours per night: ________ Quality: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach

Do you awaken stiff and loosen as the day goes on? ☐ Yes ☐ No

Do you generally feel refreshed after a quality night of sleep? ☐ Yes ☐ No

Exposures:

Do you smoke? ☐ Yes ☐ No Quantity per day? _______ Number of years? ________

Is your home environment smoke filled? ☐ Yes ☐ No

In your work environment are you regularly exposed to: smoke ☐ Yes ☐ No

toxic chemicals ☐ Yes ☐ No

Exercise:

Type: __________________ Frequency: __________________ Duration: __________________

Type: __________________ Frequency: __________________ Duration: __________________

Nutrition:

Approximately what percentage of your diet contains fruits and vegetables?

☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Does your diet contain large quantities of any of the following?

☐ Red Meat ☐ Poultry ☐ Refined flour ☐ Artificial Sweeteners

Do you drink: Water ☐ Yes ☐ No Quantity per day __________

Coffee ☐ Yes ☐ No Quantity per day __________

Soda ☐ Yes ☐ No Quantity per day __________

Alcohol ☐ Yes ☐ No Quantity per day __________

Are you currently on any special diet? If so, please describe:

____

____

Stress:

Do you believe that stress may be affecting your health? ☐ Yes ☐ No

Are you interested to learn how nutrition and/or stress affect your health? ☐ Yes ☐ No