# Welcome to Our Office!

Our purpose is to educate and adjust as many families as possible towards optimal health through natural chiropractic care.

**Brooke Stillwell Chiropractic**
www.stillwellchiropractic.com

## Patient Information

Patient: ____________________________________________
Last First Preferred

Address: ____________________________________________

____________________________________________
City State Zip Code

Birth date: ______ /______ /______ Age: __________
Home #: ____________________________________________
Cell #: ____________________________________________
Occupation: ____________________________________________
Email: ____________________________________________
Who may we thank for referring you?
____________________________________________

## Family Information

☐ Single ☐ Separated ☐ Divorced ☐ Widowed

☐ Married: Spouse's name: ____________________

Children's names and ages:

1. ____________________________________________
2. ____________________________________________
3. ____________________________________________
4. ____________________________________________
5. ____________________________________________

## Reason For Visit

Please circle all that apply: Check up / Wellness Care / Specific condition

Symptoms: ____________________________________________

____________________________________________

Have you had similar problems in the past? ______________

Have you seen a chiropractor in the past? __________ Dates: __________

Rate the severity of your symptoms on a scale of
1 (least pain) to 10 (severe pain): ____________________

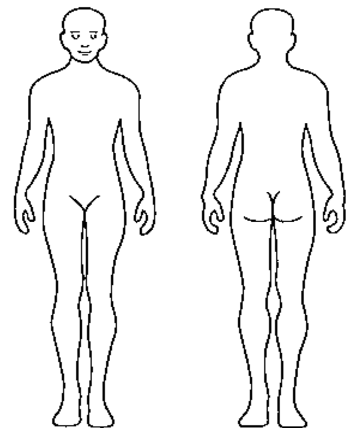
What does this interfere with? ☐ Work ☐ Sleep ☐ Recreation ☐ Daily activity

What activities or movements are painful to perform? (Check all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Bending

☐ Lying down ☐ Getting up from a seated position

*Mark an X on the picture where you are experiencing your symptoms*



What treatment have you already received for this condition? ____________________________________________

____________________________________________

Are you currently taking any medications for this condition?____________________________________________

If you did not have this issue, what would you do more of? ____________________________________________

____________________________________________

## Current Physical Stresses

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone, or stand at a machine for most of the day? ________________________________________

________________________________________

While at work do you stand or work on a concrete floor? ☐ Yes ☐ No
How long is your commute each way? _________ How many hours do you typically work in a week? _________
Please describe your exercise/sports program including type and frequency:

________________________________________

How many hours of sleep do you typically get? _________ Do you sleep well? ☐ Yes ☐ No
Do you ever sleep on your stomach? ☐ Yes ☐ No How old is your mattress? ________
Do you wear orthotics (foot supports) or a heel lift? ☐ Yes ☐ No If yes, for how many years? _______
Do you use a cervical pillow? ☐ Yes ☐ No

## History of Physical Trauma

List any **surgeries** that you have had: (Please list dates and reason for surgery)

________________________________________
________________________________________
________________________________________

**Significant childhood injuries** (fractures, stitches, falls, sports-related, etc.): (Please list dates, injury, and treatment)

________________________________________
________________________________________
________________________________________

**Significant adult injuries** (fractures, stitches, falls, sports-related, etc.): (Please list dates, injury, and treatment)

________________________________________
________________________________________
________________________________________

List any **motor vehicle** accidents: (Even if no known injuries)

________________________________________
________________________________________

## History of Chemical Stresses

How many fast food meals do you eat per week? _________
How many alcoholic beverages do you drink per week? _________
Do you use tobacco products? ☐ Yes ☐ No Are you exposed to second hand smoke? ☐ Yes ☐ No
How many glasses of water do you drink per day? _________
How many caffeinated beverages (coffee, tea, or cola) do you drink per day? _________
How many packets of artificial sweeteners do you consume a day? _________
Please list any prescription or over the counter drugs that you are currently taking:

________________________________________

How would you rate your current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

## History of Emotional Stresses

Please rate your level of stress (1-5): (0 if not applicable / 1 is mild stress / 5 is severe stress)

___Childhood ___Commuting ___Finances ___School ___Work
___Friends ___Family ___Verbal Abuse ___Addictions ___New Job
___Parent's divorce ___Divorce/separation ___Loss of a love one ___Spouse/significant other
___Chronic illness or disability

How would you rate your emotional/mental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
What are your top 3 health goals?
1. ______________________________ 2. ______________________________
3. ______________________________

# Symptoms

Below is a list of health issues that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

## Check any of the following health issues you have ever had:

- ☐ Pneumonia
- ☐ Measles
- ☐ Influenza
- ☐ Eczema
- ☐ Rheumatic Fever
- ☐ Thyroid Imbalance
- ☐ Heart Disease
- ☐ Mental Disorders
- ☐ Polio
- ☐ Smallpox
- ☐ Heart Attack
- ☐ Mumps
- ☐ Anemia
- ☐ Epilepsy
- ☐ Pleurisy
- ☐ Whooping Cough
- ☐ Diabetes
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Chicken Pox

## Check any of the following you had in the past year:

### Gastrointestinal

- ☐ Poor Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Excessive Appetite
- ☐ Excess Weight
- ☐ Significant Weight Loss
- ☐ Gas or Bloating after meals
- ☐ Abdominal Cramps
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Black/Bloody Stool
- ☐ Diagnosed IBS, Crohn's, Diverticulitis, Colitis

### Nervous System

- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Forgetfulness
- ☐ Fainting
- ☐ Cold Extremities
- ☐ Irritability
- ☐ Attention Deficit
- ☐ Dizziness
- ☐ Confusion
- ☐ Convulsions

### General

- ☐ Headaches
- ☐ Migraines
- ☐ Loss of Sleep
- ☐ Allergies
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Osteoporosis/Osteopenia

### Genito-Urinary

- ☐ Bladder Trouble
- ☐ Discolored Urine
- ☐ Painful Urination
- ☐ Excessive Urination

### Male / Female

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate Dysfunction
- ☐ Infertility Problems
- ☐ Other:

______________________________________________

______________________________________________

### Cardiovascular / Respiratory

- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ High Cholesterol
- ☐ Stroke

### Family History

The following family members have the same or similar problem(s) as I do:

- ☐ Mother
- ☐ Sister
- ☐ Spouse
- ☐ Father
- ☐ Brother
- ☐ Child

### EENT

- ☐ Vision Problems
- ☐ Sinus Infections
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Tinnitus

## Pregnancy Disclaimer

X-ray images of your spine may be performed during this visit. If you are a female of child bearing age, is there a possibility that you could be pregnant?

☐ Yes ☐ No

## Visit Payment

All charges will be discussed before any services are rendered. It is our policy that all new patients joining our practice pay for these services in full on this initial visit. My method of payment today will be:

☐ Cash ☐ Check ☐ Credit Card ☐ Previously paid

Signature: ______________________________ Date: ____________________

# HIPPA Notice of Privacy Practices

**Brooke Stillwell Chiropractic**
**205 Turnpike Road**
**Southborough, MA 01772**
**(508) 353-0483**

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## 1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## 2. Your Rights

- **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
- **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

## 3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **March 14th, 2007.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

# Notice of Privacy Practices

We are concerned with protecting your privacy especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policy and procedures. We encourage you to read this document for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal information, we would be happy to address them.

I have received a copy of the HIPAA for Brooke Stillwell Chiropractic.

______________________________ ____/____/____

Signature Date

## Appointment Reminders and Health Care Information Authorization

The following office procedures allow Brooke Stillwell Chiropractic to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including email) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- We would like to be able to refer others to speak with you about your experience at Brooke Stillwell Chiropractic.
- We often take and post photos of our practice members/patients in the office and in our newsletters

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Brooke Stillwell Chiropractic.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

______________________________ ______________

Patient name printed Date

______________________________ ______________

Patient Signature BSC representative

______________________________ ______________

Personal representative printed Personal representative's relation to patient

______________________________ ______________

Personal representative signature BSC representative