MOVE MOUNTAINS
CHIROPRACTIC

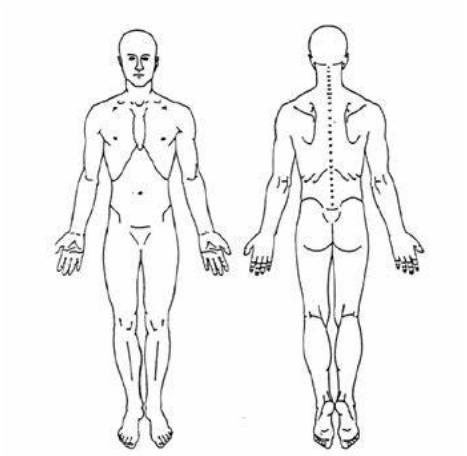
New Patient

Name:_____ **DOB:**_____ **Age:**____ **M F**
Address:_____
Phone:_____ **Email:**_____
Occupation:_____ **Employer:**_____
Status: Single Married Widow **Names/Ages of Children:**_____
Emergency Contact:_____

How did you hear about our office? _____

What is your main concern? Primary:_____**Secondary**:_____
How long has this been going on?_____ **How did it start?** _____
Frequency: Intermittent Constant On/Off Infrequent **Worse**: Morning Night All Day
What aggravates it?_____ **What relieves it?** _____
Have you had this before? No Yes **If yes, how often and since when?** _____
Have you seen anyone else for this problem? _____
Do you have any other health concerns? _____
Have you been to a chiropractor before? _____ **Who?** _____

Mark on the diagram where your pain exists:
A=ache **D**= dull **T**=tingling **S**=sharp/stabbing
N=numbness **B**=burning **R**=radiating



Rate your pain on a scale of 1-10:
Primary: 1 2 3 4 5 6 7 8 9 10
Secondary: 1 2 3 4 5 6 7 8 9 10

Mark Past (P) or Current (c) if you have ever experienced:

____Headaches/Migraines
____Dizziness/Loss of balance
____Ringing/Buzzing in the ear
____Asthma
____Diabetes
____Neck stiffness
____Menstrual Pain/Irregularity
____Osteoporosis
____Changed bowel/bladder control
____Fatigue/Irritiability
____Indigestion/Heartburn
____Sleeping problems
____Digestive problems
____Sudden/Recent weight loss
____Blood pressure problems
____Heart disease
____Stroke
____Blackouts/Blurry vision
____Recurrent ear/nose/throat infections
____Cancer
____Increased urinary frequency
____Broken bones

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Concentrating	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Doing Computer Work	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Gardening	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Playing Sports	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Recreational Activities	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sleeping	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Carrying	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Dancing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Dressing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Lifting	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Pushing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Rolling Over	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Standing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Working	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Climbing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Doing Chores	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Driving	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Reading	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Running	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sitting to Standing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to perform

List any medications/supplements:_____

_____

_____

Have you had any spinal x-rays taken in the last 12 months? No Yes

List any major illnesses and when diagnoses:_____

List any surgeries and when:_____

List any car accidents and when:_____

List any hereditary conditions the doctor should be aware of:_____

Is there anything else we should be aware of in regards to your health?_____

Social History

1. **Smoke** Y N **How often?**_____
2. **Alcohol** Y N **How often?**_____
3. **Recreational Drug use** Y N **How often?**_____

I hereby authorize payment to be made directly to Move Mountains Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Move Mountains Chiropractic for any and all services I receive at this office.

_____ _____

Patient or Authorized Person's Signature Date Completed

_____ _____

Doctor's Signature Date Form Reviewed

INFORMED CONSENT

Regarding: Chiropractic Adjustments, Modalities and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures and possible stroke (which occurs at a rate between one instance per one million to one per two million) have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments, and all other procedures provided at Move Mountains Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____

Patient or Authorized Person's Signature Date

Regarding: X-rays/Imaging Studies

Females Only: please read carefully and initial by each objective, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

___ The first day of my last menstrual cycle was on _____ (Date)
___ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge. I am not pregnant.

By my signature below I am acknowledging that the doctor and/or member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____

Patient or Authorized Person's Signature Date

NOTICE OF PRIVACY POLICY

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as directed by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign.

Permitted Disclosures:

1. Treatment purposes - discussion with other health care providers involved in your care
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source
4. For workers compensation purposes - to process a claim or aid in investigation
5. Emergency - in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or the general public
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes
9. Deceased person - discussion with coroners and medical examiners in the event of a patient's death
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

Your Rights:

1. To receive an accounting disclosures
2. To receive a paper copy of the comprehensive "Detailed" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree with them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to make a copy on a disc, we would be more than happy to accommodate you.

Complaints:

If you wish to make a formal complaint about how we handle your health information, please call Pamela Voss at (843) 663-0274. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complain to:

DHHS Office of Civil Rights
200 Independence Ave, SW
Room 509F HHH Building
Washington DC 20201

Patient Initials:_____

NOTICE OF PRIVACY POLICY continued...

I have received a copy of Move Mountains Chiropractic's Patient Privacy Notice. I understand duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further my rights as well as the practices understand that this office reserves the right to amend this 'Notice of Privacy Practice' at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this 'Notice' is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's name (printed) DOB

_____ _____

Patient or Authorized Person's signature Date