



Queensbury Family Chiropractic
ADULT HISTORY FORM

To help us serve you better, please complete the following information.
We look forward to coaching you to build better health for you and your family.

PERSONAL INFORMATION:

Name: _____ Age: _____ Date: _____

Address: _____ City/State/ Zip: _____

Home Phone #: (____)____-____ Work #: (____)____-____ Cell #: (____)____-____

Best Time To Contact: _____ Email Address: _____@_____.com
(* Would you like to receive our Wellness E-Newsletter for FREE?*)

Male: ____ Female: ____ Status: Single/ Married/ Divorced/ Widowed

Social Security #: _____ Driver's License #: _____ D.O.B.: _____

Employer Name And Address: _____ Occupation: _____

Children, Names and Ages:

(Child #1, Age) _____ (Child #2, Age) _____
(Child #3, Age) _____ (Child #4, Age) _____

Reason for consulting our office? Wellness Evaluation: ____ or Chief Complaint: _____

Who may we thank for referring you to our office? _____

Emergency Contact: _____ Phone: _____

Your WELLNESS Profile



Place an "X" on the scale above marking where you believe your level of health and wellness is **NOW**.
Place an "O" on the diagram indicating where you would **LIKE** your health and wellness to be.

(Continue on to next page)

Your HEALTH Profile

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" page.

Health Concerns:	Rate Severity 1 = mild 10= worst imaginable	When did this start?	Are symptoms Constant or Intermittent?	Did problem begin with injury?
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Since the problem started, it is: ___ The Same ___ Getting Better ___ Getting Worse

What makes the problem worse? _____

What, if anything makes it feel better? _____

Does this interfere with your: ___ Work ___ Leisure ___ Sleep ___ Sports

___ Other: _____

Have you seen other doctors for this condition? ___ Chiropractor ___ Medical Dr. ___ Other

Name/ Address: _____

Date: _____ What was the diagnosis? _____

Name/ Address: _____

Date: _____ What was the diagnosis? _____

Your General History

List all *Medications* you are taking and why: (Prescription and non-prescription)

List all *Supplements* you are taking and why:

Have you had any *Surgeries or Hospitalizations?* (Please include all surgeries)

Date: _____

Date: _____

Date: _____

What do you do for a living? _____

Have you ever had any work related injuries? _____

Have you ever had any slips, falls or auto accidents? _____

On a scale of 1-10 describe your Psychological/Emotional stress levels:

(1= none/ 10=extreme)

Home: _____

Work: _____

Financial: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits: _____ Exercise habits: _____ Sleep: _____ Mind-set: _____

Please answer the following **Life Style Habits**:

Sleeping Position: _____ Back _____ Side _____ Stomach (# of pillows used under head: _____)

How many hours per night? _____ How old is your mattress? _____

Do you smoke? _____ (If Yes, how many per day _____)

How Many 8oz glasses per day of the following do you drink:

____ Water ____ Soda ____ Coffee ____ Juice ____ Milk ____ Tea ____ Alcohol

Neurologic Scans and Systems Review

Your central nervous system (brain and spinal cord) is the master controller of your body. It controls the function of every cell, tissue and organ. The connection between your brain and your body is through the spinal nerves: sensory, motor and autonomic nerves. Your autonomic nervous system controls the functions of organs, blood vessels and glands. Please review the following systems to determine if there may be a connection between your health profile and your nerve interference.

Patient Name _____ Date _____

SYSTEM REVIEW: Place an (x) next to the symptoms you have ever experienced, even if they do not seem related to your current problem.

Cervical Nerves

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> eye strain | <input type="checkbox"/> red eyes | <input type="checkbox"/> vision problem | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> ear infection | <input type="checkbox"/> ringing in the ear | <input type="checkbox"/> ear discharge | <input type="checkbox"/> crave sweets |
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> sinusitis | <input type="checkbox"/> runny nose | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> canker sores | <input type="checkbox"/> sore throat | <input type="checkbox"/> sore gums | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> inner ear problems | <input type="checkbox"/> speech difficulty | <input type="checkbox"/> cavities | <input type="checkbox"/> tonsillitis |
| <input type="checkbox"/> hoarse/laryngitis | <input type="checkbox"/> headaches | <input type="checkbox"/> migraines | <input type="checkbox"/> emotional instability |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> dizziness | <input type="checkbox"/> anxiety | <input type="checkbox"/> insomnia |

Upper Thoracic Nerves

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> chest pain | <input type="checkbox"/> pain over heart | <input type="checkbox"/> difficult breathing |
| <input type="checkbox"/> persistent cough | <input type="checkbox"/> bronchitis | <input type="checkbox"/> coughing phlegm | <input type="checkbox"/> coughing blood |
| <input type="checkbox"/> rapid heartbeat | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> heart problems | <input type="checkbox"/> numbness in the hands |
| <input type="checkbox"/> lung problems | <input type="checkbox"/> fluid retention | <input type="checkbox"/> pleurisy | <input type="checkbox"/> difficulty in swallowing |
| <input type="checkbox"/> nausea | <input type="checkbox"/> gall bladder attacks | <input type="checkbox"/> bloating | <input type="checkbox"/> intolerance to fatty foods |

Mid Thoracic Nerves

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> poor appetite | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> gastric ulcer | <input type="checkbox"/> crave sweets |
| <input type="checkbox"/> difficult swallowing | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> liver trouble |
| <input type="checkbox"/> vomiting food | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> immune deficiencies |
| <input type="checkbox"/> constipation | <input type="checkbox"/> pancreatitis | <input type="checkbox"/> black stool | <input type="checkbox"/> hypoglycemia |

Lower Thoracic Nerves

- | | | | |
|------------------------------------|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> allergies | <input type="checkbox"/> sneezing | <input type="checkbox"/> overwhelmed | <input type="checkbox"/> digestive complaints after eating |
|------------------------------------|-----------------------------------|--------------------------------------|--|

- () appendix problems () bladder problems () kidney problems () testicular or ovarian problems
 () bladder infections () swollen ankles () dizziness upon standing

Lumbar Nerves

- () bladder trouble () IBS () bad breath () flatulence
 () bowel problems () painful urination () infertility () dark circles under eyes
 () impotence () dysmenorrhea () prostate problems () reproductive disorders
 () female problems () hemorrhoids () varicose veins () hormonal imbalances

YOUR WELLNESS GOALS: At our office we concern ourselves with YOUR health and YOUR wellness goals. (Please list your goals for your health and wellness in the spaces provided).

Physical Goals:	Nutritional/Biochemical Goals:	Psychological/ Emotional Goals:
Ex. Sleep Better	Ex. Lose Weight	Ex. Be More Organized

Have you ever:

- Bought bottled water: Yes No
- Belonged to a health club: Yes No
- Consumed vitamins or supplements Yes No
- If there is a need for dietary changes would you like to know? Yes No
- If there is a need for specific exercises would you like to know? Yes No
- If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance? Yes No

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature _____ Date: _____

Thank you for filling out this form. It is your first step to Optimal Health!
 Return this to our staff along with your Driver's License

Informed Consent for Chiropractic Care

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. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name: _____ Signature: _____ Date: _____

X-Ray /Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Print Name: _____ 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 Informed Consent and hereby grant permission for my child to receive chiropractic care.

Print Name: _____ Signature: _____ Date: _____

Privacy Notice

TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Queensbury Family Chiropractic will be provided to me upon my request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Queensbury Family Chiropractic to provide treatment to me, and also necessary for Queensbury Family Chiropractic to obtain payment for that treatment and to carry out its health care operations. Bruce Steinberg, DC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice prior to my signing this Consent.
2. Queensbury Family Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by Queensbury Family Chiropractic.
 - a.) a postcard mailed to me at the address provided by me; and
 - b.) Telephoning my home or cellular phone and leaving a message on my answering machine or with the individual answering the phone.
4. Queensbury Family Chiropractic may use and/or disclose my PHI to the third party (which includes information about my health or condition and the treatment provided to me) in order to treat me and obtain payment for that treatment, and as necessary for Queensbury Family Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request that Queensbury Family Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Queensbury Family Chiropractic is not required to agree to any restrictions that I have requested. If Queensbury Family Chiropractic agrees to a requested restriction, then the restriction is binding.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocations shall not apply to the extent that Queensbury Family Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this Consent at any time, Queensbury Family Chiropractic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, the Queensbury Family Chiropractic will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed) _____ Signature of Individual _____

Signature of Legal Guardian/if a minor _____ Relationship _____

Date Signed: ____/____/____ Witness: _____

Releases

I hereby request and consent to receive chiropractic services, including, but not limited to, adjustments, various manual and mechanical procedures, various modes of therapy and X-rays, or me (or for the patient named below, for whom I am legally responsible) by any licensed Doctors of Chiropractic who now or in the future treat me while employed by, working with, are associated with, or providing coverage services for this office (collectively known as the "Treating Doctor(s)"), including those working at any office associated with the Treating Doctor(s) (collectively known as the "Staff".) I authorize the Treating Doctor(s) and Staff to request medical records as needed from any source.

Initials: _____

I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize and assign any benefits to be paid directly to the Doctor's Office. Any payments will be immediately credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable.

Initials: _____

In consideration of services rendered, I hereby assign to the provider of the services and his assignees so much of my third party insurer, first party no-fault automobile or Worker's Compensation insurance benefits and rights, attendant thereto, as shall equal the full amount of the bill for such services and the provider or his assign may secure in my name.

Initials: _____

Kindly furnish my doctors, insurance company, attorney and any other involved parties or their representatives all information you may have regarding my condition while under your treatment or observation, including but not limited to the history obtained, X-ray, testing, physical findings, diagnosis and prognosis.

Initials: _____

I have had the opportunity to review and understand a Privacy Notice. I understand that I have the right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. There are no restrictions, unless explicitly noted here.

Initials: _____

I have read and understood the above information:

Patient /Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

Financial Policy & Profile

PAYMENT IS DUE AS SERVICES ARE RENDERED

Our office is a cash practice, all services are due when rendered, unless other arrangements have been made prior to treatment.

Method of Payment:

Cash: _____ Check: _____ Credit Card: _____ HAS: _____ Insurance: _____

Group Insurance

Patients are responsible for payment at the time of their visit. As a courtesy we will verify your insurance. Verification is not a guarantee of payment. The insurance contract is between the patient and the insurance company. We do accept assignment once verification of coverage has been made. You are responsible for any unpaid balance by your insurance company.

Insurance Company: _____ Policy #: _____

Group #: _____ Insurance Phone: _____

Primary Insured: _____ You/Spouse/Other _____

Medicare

The doctor is a non-participating Medicare provider. Medicare patients are required to pay cash as services are rendered and we will submit your claims as a courtesy to you. Medicare patients must present their Medicare card at the onset of treatment. The only treatment Medicare covers is acute care.

Workers Compensation and Personal Injury

We are a cash practice, if you have been injured; you are still required to pay at the time of service. You will be reimbursed by your insurance carrier.

My Certification

(Assignment & Release)

I certify that the above information is correct and I request services. I certify that I, and/or my dependant(s), assign directly to Dr. Bruce P. Steinberg all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not they are paid by insurance.*** I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient

_____/_____/_____
Date