ABRAMS
ACUPRESSURE & CHIROPRACTIC

Patient Information

Today's Date: ___ / ___ / _____

First Name: ______________________________

Nickname: ___________ Middle Name: _______________

Last Name: ______________________________

Date of Birth: ____ - ____ - _______ Age: ____

Gender: ☐ Male ☐ Female ☐ Unspecified

Marital Status: M S W D # of Children: _________

SSN: ____ - ____ - _______

Address 1: ______________________________

Address 2: ______________________________

City/State/Zip: ______________________________

Primary Phone: ( ) ________ - _______________

Secondary Phone: ( ) ________ - _______________

Mobile Phone: ( ) ________ - _______________

Employment Status: ☐ Employed ☐ FT Student ☐ PT Student ☐ Other ☐ Retired ☐ Self-Employed

Employer (if applicable): ______________________________

Home Email: ______________________________

Work Email: ______________________________

By providing my email address, I authorize my doctor to contact me via the email address provided.

Preferred Contact Method: ☐ Primary Phone ☐ Secondary Phone ☐ Mobile ☐ Home Email ☐ Work Email

Referred by: ______________________________

Signature: ______________________________

Race: ☐ Black/African American ☐ Hispanic ☐ White ☐ Asian Indian ☐ Chinese ☐ Asian ☐ Korean ☐ Vietnamese ☐ Japanese ☐ Guamanian or Chamorro ☐ Filipino ☐ Samoan ☐ Native Hawaiian or other Pacific Island ☐ American Indian/Alaskan Native ☐ I choose not to specify

Multi-Racial: ☐ Yes ☐ No ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Armenian ☐ French ☐ German ☐ Tagalog ☐ Italian ☐ Portuguese ☐ Korean ☐ Arabic ☐ Polish ☐ Japanese ☐ French Creole ☐ Hindi ☐ Persian ☐ Urdu ☐ Gujarati ☐ American Sign Language ☐ Greek ☐ I choose not to specify

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If yes, how often do you smoke? ☐ Current every day smoker ☐ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Interest *Very Interestet*

Security Question (choose only one question, then give the answer to that question): ☐ What is the name of your favorite pet? ☐ In what city were you born? ☐ What high school did you attend? ☐ What is the name of your favorite movie? ☐ What is your mother's maiden name? ☐ On what street did you grow up? ☐ What was the make of your first car? ☐ When is your anniversary?

Security Answer: ______________________________
must be at least 6 characters long

Current medications, including frequency and dosage if known. If there are no current medications, check here: ☐

1. ____________________ Start Date: ___ / ___ / _____
2. ____________________ Start Date: ___ / ___ / _____
3. ____________________ Start Date: ___ / ___ / _____
4. ____________________ Start Date: ___ / ___ / _____
5. ____________________ Start Date: ___ / ___ / _____
6. ____________________ Start Date: ___ / ___ / _____
7. ____________________ Start Date: ___ / ___ / _____
8. ____________________ Start Date: ___ / ___ / _____

List any known allergies you have had to medications. If no allergies are known, check here: ☐

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Has any doctor diagnosed you with Hypertension presently? ☐ Yes ☐ No If yes, describe: ____________________

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If yes, what kind? ☐ Type I ☐ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c>9.0%? ☐ Yes ☐ No ☐ Not Sure

If yes, other comments regarding Diabetes: ______________________________

Have you had an X-Ray, CT Scan, or MRI of your LOW BACK spine in the past 28 days? ☐ Yes ☐ No

Patient First Name: ______________________ Last Name: ______________________ MI: _______

Confidential Case History

Please complete this questionnaire. Your answers will help us determine if Chiropractic can help you.
If we sincerely believe your condition will not respond satisfactory to treatment, we will not accept your case.

What is your major complaint? ______________________

Do you have any other complaints? ______________________

When did this begin? ______________________

Since the condition started has it gotten better, same or worse? ______________________

Have you had the same or similar conditions in the past? ______________________

Is there anything that makes your condition ***worse***? ______________________

Is there anything that makes your condition ***better***? ______________________

Select all that describe your pain: ☐*constant* ☐*aggravated by movement* ☐*come & go* ☐*getting worse* ☐*staying the same*

Select all experiences that you have related to this pain: ☐*weakness* ☐*radiating pain* ☐*dizziness* ☐*numbness* ☐*blurred vision* ☐*vomiting* ☐*nausea* ☐*burning* ☐*pins & needles* ☐*dull & aching* ☐*sharp* (if so please explain): ______________________

Pain Level Chart

please indicate the pain level you are currently experiencing

no pain — **unbearable pain**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

*please select all the activities that you find difficult to do **now** due to your discomfort*

☐ sleep through the night
☐ get out of bed
☐ make your bed
☐ bathe yourself
☐ wash, comb or dry hair
☐ bend over a sink for more than 10 minutes
☐ go to the bathroom
☐ put on socks, shoes or clothing
☐ walk up one flight of stairs
☐ walk down one flight of stairs
☐ crawl on all fours
☐ carry laundry basket, groceries or child
☐ open a heavy door
☐ sit in a chair for 30 minutes
☐ sit and work at a desk for one hour
☐ use pencil, scissors, screwdriver or pliers
☐ cross legs
☐ reach in front or overhead to high shelves
☐ stand for 30 minutes
☐ travel on journeys that take over one hour
☐ push or pull vacuum or lawn mower
☐ turn door knob
☐ wash windows or walls
☐ shovel snow or dirt
☐ bend over to clean bathtub
☐ get up from a low seat
☐ lift heavy suitcase (about 40 lbs.)
☐ walk for one mile
☐ enjoy hobbies or social activities
☐ enjoy sexual activities

Are there any of the above activities that you had a difficult time doing **before** you had this discomfort? ______________________

please select the problem area(s) or condition(s) you have experienced

☐ Headaches
☐ Sinus/Allergy
☐ Neck
☐ Stressed Shoulders
☐ Mid-Back Pain
☐ Tight/Sore Muscles
☐ Leg & Hip
☐ Stiffness
☐ Car Accident
☐ Chemical Stress
☐ Scoliosis
☐ Numbness (Hands/Feet)
☐ Loss of Energy
☐ Wrist or Joint Pain
☐ Physical Stress
☐ Stomach
☐ Low-Back Pain
☐ Poor Posture
☐ Sports Injury
☐ Emotional Stress

How long has it been since you really felt good?

____

List other doctors who have treated this condition:

____

Have you had previous chiropractic care? ☐*yes* ☐*no*

____

Do these conditions disrupt?

☐ Career/Work
☐ Family Life
☐ Ability to Exercise
☐ Sleeping Patterns
☐ Social Life

What methods have you tried?

☐ Exercise
☐ Physical Therapy
☐ Prescription Drugs
☐ Massage
☐ Chiropractic
☐ Nothing

Please list any surgeries and dates: ______________________

Have you ever been in an accident or personal injury? ☐*yes* ☐*no* When? ____________ Describe: ______________________

____

Insurance Agreement

Patient Agreement Assignment & Release: I, the undersigned, have insurance coverage with ______________________ and assign directly to Dr. Abrams all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient/Guardian Signature: ____ **Date**: ___ / ___ / _____

Insured's First Name: ____________________________ MI:_______ Last Name: ______________________________________

Insured's Date of Birth: ____ - ____ - _______ Insured's ID #: _____________________ Group #: _____________________

Do you have a secondary insurance? ☐ *yes* ☐ *no* If yes, name: ____

Cash Agreement

Patient Agreement: I, the undersigned, will be a cash paying patient and understand that I am financially responsible for all charges incurred for examinations, consultations, and treatment rendered. I authorize Dr. Abrams to provide these services to ______________________.

Patient/Guardian Signature: ____ **Date**: ___ / ___ / _____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health concerns that you may have for those members:

____

____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient/Guardian Signature: ____ **Date**: ___ / ___ / _____

To Be Performed By Clinic Staff:

Height: ________ inches Weight: ________ pounds BP: ________/________

NOTICE OF PRIVACY PRACTICES

A. OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning
your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at
this time. We realize that these laws are complicated, but we must provide you with the following important information:
· How we may use and disclose your IIHI, your privacy rights in your IIHI, our obligations concerning the use and disclosure of your IIHI. The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.
B. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS
The following categories describe the different ways in which we may use and disclose your IIHI.
1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and therapists, or indirectly with any provider we refer you to - may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.
C. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:
1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
· Maintaining vital records, such as births and deaths, reporting child abuse or neglect, preventing or controlling disease, injury or disability, notifying a person regarding potential exposure to a communicable disease, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting reactions to drugs or problems with products or devices, notifying individuals if a product or device they may be using has been recalled, notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information, notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.
4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
· Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement, concerning a death we believe has resulted from criminal conduct, regarding criminal conduct at our offices, in response to a warrant, summons, court order, subpoena or similar legal process, to identify/locate a suspect, material witness, fugitive or missing person, in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)
5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
7. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
9. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

Patient/Guardian Signature: ______________________________ **Date**: ___ / ___ / _____