

## General Information

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_  
Fax # \_\_\_\_\_ Cellular # \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ # of Kids \_\_\_\_\_  
Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Name of Spouse \_\_\_\_\_  
Names and ages of Kids \_\_\_\_\_  
Who May we thank for referring you? \_\_\_\_\_  
Main reason for consulting our office today? \_\_\_\_\_  
\_\_\_\_\_

**\*\*Please check if you are here for any of the following:** \_\_\_\_\_ Car Accident \_\_\_\_\_ Work Injury \_\_\_\_\_ Other Injury

## Your Health Profile

**Why this form is important** - As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a **lifetime** of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late! Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential.

**The Beginning Years** - Many of the health challenges that people face later in life have their origins in stresses from the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

**Birth History** - Please check those items that apply to you

\_\_\_\_ Mother smoked/drank/drugs in pregnancy \_\_\_\_\_ Epidural/Meds in labor \_\_\_\_\_ Breech Vaginal Delivery  
\_\_\_\_ Forceps Delivery \_\_\_\_\_ Vacuum Extractor used \_\_\_\_\_ Labor Induced  
\_\_\_\_ C-Section Delivery \_\_\_\_\_ Premature/Overdue \_\_\_\_\_ Complications  
\_\_\_\_ Very Short Labor \_\_\_\_\_ Very Long Labor  
\_\_\_\_ Other \_\_\_\_\_

**Childhood Years (Age 0-17 yrs)** - Please check those items that apply to you

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Recurrent Childhood Illness | <input type="checkbox"/> Serious Falls                 | <input type="checkbox"/> Active in Sports        |
| <input type="checkbox"/> Car Accident(s)             | <input type="checkbox"/> Surgery/Stitches              | <input type="checkbox"/> Alcohol/Drug Abuse      |
| <input type="checkbox"/> Smoker                      | <input type="checkbox"/> Antibiotics/Other Medications | <input type="checkbox"/> Vaccinated              |
| <input type="checkbox"/> Broken Bones                | <input type="checkbox"/> Severe Emotional Stress       | <input type="checkbox"/> Under Chiropractic care |
| <input type="checkbox"/> Other _____                 |  |  |

**Adult Years (Age 18 to present)** - Please check those items that apply to you

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Present Smoker   | <input type="checkbox"/> Former Smoker    | <input type="checkbox"/> OTC/Prescription Meds      |
| <input type="checkbox"/> Alcohol Use  | <input type="checkbox"/> Surgery/Stitches | <input type="checkbox"/> Play Sports                |
| <input type="checkbox"/> Car Accident(s)  | <input type="checkbox"/> Work Injury      | <input type="checkbox"/> High Job Stress            |
| <input type="checkbox"/> High Personal Stress   | <input type="checkbox"/> Sit a lot        | <input type="checkbox"/> Drive a lot                |
| <input type="checkbox"/> Poor Sleep   | <input type="checkbox"/> Not Enough Sleep | <input type="checkbox"/> Poor/Inadequate Diet       |
| <input type="checkbox"/> No Exercise  | <input type="checkbox"/> Flat Feet        | <input type="checkbox"/> Wear Orthotics/Lifts       |
| <input type="checkbox"/> Severe Health Problems   | <input type="checkbox"/> Hard Falls       | <input type="checkbox"/> Broken Bones               |
| <input type="checkbox"/> Drink Sodas  | <input type="checkbox"/> How Many?        | <input type="checkbox"/> Drink coffee/energy drinks |
| <input type="checkbox"/> Drink water How much?  | <input type="checkbox"/> Exercise         | <input type="checkbox"/> How often/what type?       |
| <input type="checkbox"/> Other Injuries _____   |   |   |
| <input type="checkbox"/> Have been under chiropractic care in the past - How long ago was your last adjustment? _____ |   |   |

**Clarifying Your Health Objectives**

In addition to the main reason for your visit today, what additional health objectives do you have for your future?

\_\_\_\_\_

Have you ever been to another doctor who put you on a Health Development Program? [ ] Yes [ ] No [ ] Not Sure  
If yes: Doctor's Name \_\_\_\_\_ [ ] Medical Doctor [ ] Chiropractor [ ] Other

How long were you able to stay on the program? \_\_\_\_\_

What were your results? \_\_\_\_\_

Are you as healthy (or healthier) today as you were 5 years ago? [ ] Yes [ ] No [ ] Don't Know

If yes, what strategies have you used? \_\_\_\_\_

Will you be as healthy (or healthier) as you are today, 5 years from now? [ ] Yes [ ] No [ ] Don't Know

If yes, what strategies will you implement to get there? \_\_\_\_\_

Interested in a nutritional program? [ ] Yes [ ] No Would like an alternative to medications? [ ] Yes [ ] No

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge.

I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

# TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion and misunderstandings.

**Adjustment:** The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of corrections is by specific adjustments of the spine.

**Health:** The 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 vertebra 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.

We do not offer diagnosis or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings we will advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

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(signature)

(date)

## Consent to evaluate and adjust a minor child

I, \_\_\_\_\_ the parent/legal guardian of  
\_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

## Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and 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: \_\_\_\_\_.

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(signature)

(date)

**PRIVACY NOTICE**

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

In the course of your care as a patient at **Cambridge Chiropractic**, we may use or disclose personal and health related information about you in the following ways:

\*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

\*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).

\*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Reminder notices may also be sent to you through the mail on postcards.

Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

\*If we are providing health care services to you based on the orders of another health care provider.

\*If we provide health care services to you in an emergency.

\*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

\*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

\*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Petrice Foxworthy. If you would like further information about our privacy policies and practices please contact: Dr. Petrice Foxworthy. This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you. This notice is effective as of April 14, 2008. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created.

My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_  
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

\_\_\_\_\_  
Personal Representative Printed Personal Representative Signature Date

\_\_\_\_\_  
Description of the authority to act on behalf of the patient.