



Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (cell) \_\_\_\_\_ Phone (work) \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Marital Status: S M D W SSN \_\_\_\_\_

Race (circle): White African American Asian Other \_\_\_\_\_ Ethnicity (circle): Hispanic or Latino Not Hispanic or Latino

Preferred Language: \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Occupation /Employer \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Spouse's Name \_\_\_\_\_ How many children/ages \_\_\_\_\_

Email Address \_\_\_\_\_

Have you ever received Chiropractic Care? Y N If yes, when was your last visit? \_\_\_\_\_

Present condition due to an injury? Y N On the Job \_\_ Auto Accident \_\_ Other \_\_\_\_\_

Has the accident been reported? Y N To Employer \_\_ Auto Carrier \_\_ Other \_\_\_\_\_

Please list the **major traumas** that you remember from childhood to the present.

Automobile Motorcycle Bicycle Sports Playground Abuse

State **type of injury and date:** \_\_\_\_\_

Have you ever hurt/injured/fractured/sprained your spine, head, neck, ribs, chest, upper or lower back, pelvis, arms, legs or hips? Y N If yes, state **type of injury and date:** \_\_\_\_\_

Have you ever been hospitalized or had surgery? Y N If yes, state **reason and dates and/or body parts and dates:** \_\_\_\_\_

**How do you describe your sleep habits?**

- Trouble falling asleep
- Trouble staying asleep
- Restful
- Other

**Sleeping posture?**

- Back
- Side
- Stomach

**Do you smoke?**

- Never
- Current every day
- Current some day
- Former

**Diet, do you eat healthy foods?**

- Yes
- No

**Did/do you drink alcohol?**

- Yes
- No

**Do you exercise regularly?**

- No Moderate
- Light Heavy

**Did/do you have occupational stress?**

- Yes
- No

**Emotional/Mental stress?**

- Yes
- No

**Drive? Daily time spent driving**

- Yes \_\_\_\_\_
- No

Are you presently under the care of another physical and/or mental health care provider? If yes, who and for what condition(s)? \_\_\_\_\_

What Medications are you taking? \_\_\_\_\_

**COMPLAINT 1 (CHECK ONLY 1 there is additional space for more complaints on next page)**

- Neck Pain Headache Migraine Upper/Mid Back Pain Low Back Pain
- Shoulder Pain Knee Pain Jaw Pain Hip Pain Other \_\_\_\_\_

**Does the pain travel or radiate anywhere?** \_\_\_\_\_

**Do you notice the pain during a certain time of day?** Morning Afternoon Evening Night

**Do you know what caused the problem?**

- Fall Trauma Accident Bending Exercise Housework Lifting
- Running Working Sports injury Turning Twisting Sleeping wrong Standing

**Frequency: How often do you feel the pain? Is it**  **daily**  **weekly**  **monthly**

0-25% (infrequent)  26-50% (comes and goes)  51-75% (semi-constant)  76-100% (Constant)

**Duration: How long does the pain last when you feel symptoms?**

Constant  Frequent  Intermittent  Occasional  Infrequent  other \_\_\_\_\_

**Onset: When did the above symptom begin?**

Childhood  Adulthood  Year of \_\_\_\_\_  Month of \_\_\_\_\_  Exactly this date \_\_\_\_\_

**Has the condition gotten better, worse or stayed the same since its onset?**

Better  Worse  Stayed the Same

**Quality: How would you describe the pain?**

Aching  Burning  Cramping  Deep  Dull  Numb  Radiating  Sharp  
 Shooting  Sore  Stabbing  Stiff  Swelling  Tight  Tingling  Throbbing

**Aggravating Factors: What makes the problem worse?**

Nothing  Most Movements  Bending  Carrying things  Coughing  Driving  
 Eating  Exercise  down stairs  Heat  Housework  Ice  
 Jogging  Lifting  Lying down  Massage  Pulling  Pushing  
 Running  Sitting  Sleeping  Sneezing  Squatting  Standing  
 Prolonged standing  Stress  Stretching  Taking a deep breath  
 Turning  Twisting  Walking  Working  lying to sitting  
 sitting to standing  lying to standing  Sitting at Computer

**Relieving Factors: What makes the problem better?**

Anti-inflammatory  Bracing  Chiropractic Care  Elevation  Exercise  Heat  Ice  
 Massage  Movement  Pain Killers  Rest  Stretching  Walking

**What activities of daily living are affected (or difficult) due to the problem?**

Bathing  Caring for children  Cleaning  Climbing stairs  Cooking  
 Doing laundry  Dressing  Driving  Eating  Exercising  
 Sitting to standing  Grooming  Housework  Lying down  Lifting  
 Lying to sitting  Oral Care  Shopping  Sitting  Sleeping  
 Standing  Stretching  Transferring  Using technology  phone call  
 Walking  Watching TV  Working  Yard work  Social activities

**On a scale of 1-10 (10 the worst pain you can imagine), what would you rate your pain TODAY**

1 2 3 4 5 6 7 8 9 10

**COMPLAINT 2 (CHECK ONLY 1 there is additional space for more complaints on next page)**

Neck Pain  Headache  Migraine  Upper/Mid Back Pain  Low Back Pain  
 Shoulder Pain  Knee Pain  Jaw Pain  Hip Pain  Other \_\_\_\_\_

**Does the pain travel or radiate anywhere?** \_\_\_\_\_

**Do you notice the pain during a certain time of day?**  Morning  Afternoon  Evening  Night

**Do you know what caused the problem?**

Fall  Trauma  Accident  Bending  Exercise  Housework  Lifting  
 Running  Working  Sports injury  Turning  Twisting  Sleeping wrong  Standing

**Frequency: How often do you feel the pain? Is it**  **daily**  **weekly**  **monthly**

0-25% (infrequent)  26-50% (comes and goes)  51-75% (semi-constant)  76-100% (Constant)

**Duration: How long does the pain last when you feel symptoms?**

- Constant     Frequent     Intermittent     Occasional     Infrequent     other \_\_\_\_\_

**Onset: When did the above symptom begin?**

- Childhood     Adulthood     Year of \_\_\_\_\_     Month of \_\_\_\_\_     Exactly this date \_\_\_\_\_

**Has the condition gotten better, worse or stayed the same since its onset?**

- Better     Worse     Stayed the Same

**Quality: How would you describe the pain?**

- Aching     Burning     Cramping     Deep     Dull     Numb     Radiating     Sharp  
 Shooting     Sore     Stabbing     Stiff     Swelling     Tight     Tingling     Throbbing

**Aggravating Factors: What makes the problem worse?**

- Nothing     Most Movements     Bending     Carrying things     Coughing     Driving  
 Eating     Exercise     down stairs     Heat     Housework     Ice  
 Jogging     Lifting     Lying down     Massage     Pulling     Pushing  
 Running     Sitting     Sleeping     Sneezing     Squatting     Standing  
 Prolonged standing     Stress     Stretching     Taking a deep breath  
 Turning     Twisting     Walking     Working     lying to sitting  
 sitting to standing     lying to standing     Sitting at Computer

**Relieving Factors: What makes the problem better?**

- Anti-inflammatory     Bracing     Chiropractic Care     Elevation     Exercise     Heat     Ice  
 Massage     Movement     Pain Killers     Rest     Stretching     Walking

**What activities of daily living are affected (or difficult) due to the problem?**

- Bathing     Caring for children     Cleaning     Climbing stairs     Cooking  
 Doing laundry     Dressing     Driving     Eating     Exercising  
 Sitting to standing     Grooming     Housework     Lying down     Lifting  
 Lying to sitting     Oral Care     Shopping     Sitting     Sleeping  
 Standing     Stretching     Transferring     Using technology     phone call  
 Walking     Watching TV     Working     Yard work     Social activities

**On a scale of 1-10 (10 the worst pain you can imagine), what would you rate your pain TODAY**

1    2    3    4    5    6    7    8    9    10

*IF YOU HAVE MORE THAN 2 COMPLAINTS, PLEASE FILL OUT AN ADDITIONAL COMPLAINT FORM  
(AVAILABLE BOTH ONLINE AND AT FRONT DESK)*

**REVIEW OF SYSTEMS**

**Have or had the following Musculoskeletal symptoms:**

- Arm/hand pain     Feet/leg pain     Hip pain     Knee pain     Lower back pain     mid back pain  
 muscle or joint pain     neck pain     redness of joints     shoulder pain     stiffness  
 swelling of joints     upper back pain     scoliosis

**Have or had the following Cardiovascular/Respiratory symptoms**

- Cold hands/feet     Cough     Difficulty breathing     Earache/Infections     high cholesterol  
 Poor hearing     Ringing in ears     Chest pain, pressure, or discomfort     high blood pressure

**Have or had the following Head and Neck symptoms**

- Dizziness     Facial Pain     Grinding Teeth     Headache     Migraine     Jaw Clicks/Pain     head injury  
 Swollen Glands     trouble swallowing

**Have or had the following Nose symptoms:**

- Allergies     Blocked sinuses     Excessive mucus     Sinus pressure or pain     stuffiness/blockage

**Have or had the following Urinary symptoms:**

- Difficulty urinating  Kidney infections  Kidney stones  Unable to hold urine  Frequent UTI

**Have or had the following Gastrointestinal symptoms:**

- constipation  diarrhea  heartburn  nausea  Change in bowel habits  Gall Stones

**Have or had the following Endocrine symptoms:**

- cold intolerance  excessive thirst  frequent urination  heat intolerance  sweating

**Have or had the following Vascular/Hematologic symptoms:**

- calf pain with walking  cold hands and feet  ease of bruising  leg cramping

**Have or had the following Neurologic/Psychologic symptoms:**

- Depression  easily angered or irritated  fainting  confusion  nervousness  
 neuralgia  numbness  tremors  poor concentration  seizures  
 suicidal thoughts  tingling  weakness  worry/anxiety  stress

**Have or has had the following genitourinary or reproductive issues:**

- Menstrual cramps  missed periods/irregular cycle  mood swings  STDs  erectile dysfunction  hernia  
 impotence

**FEMALE ONLY**

Are you pregnant? yes no If yes, how many weeks? \_\_\_\_\_ EDD \_\_\_\_\_ Date of LMP \_\_\_\_\_

What hospital are you delivering at? \_\_\_\_\_ Number of pregnancies? \_\_\_\_\_ Number of deliveries? \_\_\_\_\_

Number of cesareans? \_\_\_\_\_ Number of miscarriages? \_\_\_\_\_ Number of days between periods? \_\_\_\_\_

What age did you start your period? \_\_\_\_\_ What age did you stop getting your period? \_\_\_\_\_

Have you had any complications with previous pregnancies? (prolonged or short labor, dystocia, pre-e, etc)

Have you had any testing? (Genetic, U/S, amnio, etc) \_\_\_\_\_

Are you planning on breastfeeding post delivery? Yes No

Did you receive an epidural during your previous deliveries?  Yes  No

**AUTHORIZATION AND RELEASE: I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Guardian's Signature Authorizing Care:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

**Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

**Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

**I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.**

**I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE OCEANSIDE CHIROPRACTIC, LLC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS \_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_**

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**Patient Signature**

**Parental Consent for Minor Patient:**

**Patient Name:** \_\_\_\_\_

**Patient age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Printed name of person legally authorized to sign for Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.**

**Printed name of person legally authorized to sign for Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_



## HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Oceanside Chiropractic, LLC to use and/or disclose Protected Health Information in accordance with the following:

### **SPECIFIC AUTHORIZATIONS:**

- I give permission to Oceanside Chiropractic, LLC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If Oceanside Chiropractic, LLC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to Oceanside Chiropractic, LLC to use my name on a welcome board, referral board, and birthday board.
- I give permission to Oceanside Chiropractic, LLC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to Oceanside Chiropractic, LLC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give Oceanside Chiropractic, LLC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Oceanside Chiropractic, LLC permission to use and disclose your protected health information in accordance with the directives listed above.

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. This authorization will remain in effect for the duration of my care at Oceanside Chiropractic, LLC plus 7 years or until revoked by me.

**RIGHT TO REVOKE AUTHORIZATION:**

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Oceanside Chiropractic, LLC. The written notice must contain the following information:

- Your name, Social Security number and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Oceanside Chiropractic, LLC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Oceanside Chiropractic, LLC will not refuse to provide treatment however, it will not be possible for Oceanside Chiropractic, LLC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Oceanside Chiropractic, LLC will be unable to contact me 3) all contact with Oceanside Chiropractic, LLC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

**HEALTHCARE AUTHORIZATION**

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

DOB: \_\_\_\_\_

Patient's name (please print): \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)**

Parent or Personal Representative name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Description of Representative's Authority to Act on Patient's Behalf: \_\_\_\_\_





## OFFICE POLICY

1. Patients at Oceanside Chiropractic are seen by appointment. Patients may call the office at **401-757-0408** and schedule an appointment. Walk Ins will be seen when an appointment is available.
2. Oceanside Chiropractic, LLC reserves the right to charge a missed appointment fee of **\$25** for any appointment missed without a phone call cancellation. It is always best to call to cancel or reschedule your appointment to avoid this fee.
3. If you have a scheduled appointment and know you will not be making it on time, please give us a call prior to your appointment so we can give other patients your time slot and can verify if your new time is available.
4. Office hours are as follows:  
Monday, Wednesday, Thursday      9 AM -12:30 PM   3 PM- 6:00 PM  
Tuesday                                      3 PM – 6 PM  
Friday    9 AM – 12:30 PM
5. Oceanside Chiropractic does offer Emergency visits during off hours for an additional fee of **\$50** for existing patients and **\$100** for new patients.  
For an Emergency visit:  
Email [drheather.oceanside@gmail.com](mailto:drheather.oceanside@gmail.com) or send a message on FaceBook
6. Payment is due at the time of service. We accept cash, check, and credit card.
7. Please notify Dr. Heather if you are in an automobile accident before your adjustment. Additional exams may need to be performed prior to your adjustment for your safety.
8. Oceanside Chiropractic is **not** a participating provider with any insurance companies. We can call and verify any out of network benefits you may have through your insurance company. Please provide the front desk with your insurance card so we may verify these benefits for you. Dr. Heather is also a non- participating provider with Medicare. Medicare will directly reimburse you, the patient. Please provide the front desk with your Medicare card. Oceanside Chiropractic **does** accept automobile insurance for our current patients if you have been in an accident. Please notify the front desk if you have been in an auto accident.
9. Oceanside Chiropractic will be closed on the following Holidays: New Years Eve/Day, Christmas Eve/Day, Memorial Day, 4<sup>th</sup> of July, Labor Day, and Thanksgiving. Patients will be given advanced noticed of any office closures.
10. Oceanside Chiropractic may close for inclement weather. Patients who are on the schedule will receive phone calls for cancellation **when possible**. If you do not have an appointment, please check our Facebook page [www.facebook.com/oceansidechiropracticwesterly](http://www.facebook.com/oceansidechiropracticwesterly) for office closures and announcements.
11. Please 'Like' our Facebook Page [www.facebook.com/oceansidechiropracticwesterly](http://www.facebook.com/oceansidechiropracticwesterly) for additional health information, promotions and announcements.
12. Further office information may also be found at our website [www.oceansidechiropractic.net](http://www.oceansidechiropractic.net)

I have read and understand the above statements.

Patient/Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_