Name ______________________________ Nickname ______________ Date ______________

DOB ______________ Age ______ Sex: M F Marital Status: S M D W Spouse Name ______________________

Address ______________________________ City ______________ State ______ Zip ________

Phone (Home) ______________________ Phone (cell) ______________________ Phone (work) ______________________

Race (circle): White African American Asian Other________ Ethnicity (circle): Hispanic or Latino Not Hispanic or Latino

Preferred Language: __________________ Emergency Contact Name/# ______________________________

Occupation /Employer ______________________ How did you hear about us? ______________________

Appointment alert via: TEXT or CALL (circle one) 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 (even if there was no known injury).

☐ Automobile (10mph+) ☐ 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 - <u>CHECK ONLY 1 AT A TIME</u> (there is additional space for more complaints on next page)

☐Neck Pain ☐Headache ☐Migraine ☐ Upper Back Pain ☐Mid Back Pain
☐Low Back Pain ☐Shoulder (L R) ☐Knee (L R) ☐Jaw Pain ☐Hip Pain (L R)
☐Foot/Ankle (L R) ☐Wrist/Hand (L R) ☐Other________

Does the pain travel or radiate anywhere? ____

Do you know what caused the problem or what you were doing at the time of injury/start of pain?

☐Fall ☐Trauma ☐Accident ☐ Bending ☐Exercise ☐Housework ☐Lifting
☐Running ☐Working ☐Sports Injury ☐Pregnancy ☐Twisting ☐Sleeping wrong ☐Standing

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

☐ 0-25% (Occasional) ☐ 26-50% (Intermittent) ☐51-75% (Frequent) ☐76-100% (Constant)

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

☐Constant ☐Frequent ☐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?

☐Bending ☐Carrying things ☐Coughing ☐Driving ☐Eating
☐Exercise ☐Going down stairs ☐Heat ☐Housework ☐Ice
☐Jogging ☐Lifting ☐Lying down ☐Massage ☐Most Movements
☐Nothing ☐Pulling ☐Pushing ☐Running ☐Prolonged Sitting
☐Sleeping ☐Sneezing ☐Squatting ☐Standing ☐Prolonged standing
☐Stress ☐Stretching ☐Taking a deep breath ☐Turning ☐Twisting
☐Walking ☐Working ☐Talking ☐Looking up/down ☐Breast/bottle feeding
☐Caring for children ☐Sitting at computer ☐Sitting to Standing ☐Lying to sitting ☐Sitting to lying
☐Lying to standing ☐Bending head ☐Light ☐Allergies ☐Hormonal changes
☐Clenching teeth ☐Grinding teeth ☐Dehydration ☐Lack of Sleep ☐Reading/eye strain
☐Electronic use ☐Caffeine intake ☐Strong Scents ☐Noise ☐Weather Changes

Relieving Factors: What makes the problem better?

☐Nothing ☐Anti-inflammatory ☐Bracing ☐Elevation ☐Exercise ☐Heat ☐Ice
☐Standing ☐Rest ☐Chiropractic Care ☐Massage ☐Movement ☐Pain Killers
☐Stretching ☐Walking ☐Sitting ☐CBD

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

☐Bathing ☐Caring for children ☐Climbing stairs ☐Dressing ☐Yard work ☐Social activities
☐Driving ☐Eating ☐Exercising ☐Sitting to standing ☐Grooming ☐Housework
☐Lifting ☐Lying to sitting ☐Oral Care ☐Shopping ☐Sitting ☐Sleeping
☐Standing ☐Stretching ☐Using technology ☐Walking ☐Watching TV ☐Working
☐Cleaning ☐Cooking ☐Doing Laundry ☐Laying Down ☐Sex ☐Toileting
☐School Work

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

0 1 2 3 4 5 6 7 8 9 10

COMPLAINT 2 - <u>CHECK ONLY 1 AT A TIME</u>

☐Neck Pain ☐Headache ☐Migraine ☐ Upper Back Pain ☐Mid Back Pain
☐Low Back Pain ☐Shoulder (L R) ☐Knee (L R) ☐Jaw Pain ☐Hip Pain (L R)
☐Foot/Ankle (L R) ☐Wrist/Hand (L R) ☐Other________

Does the pain travel or radiate anywhere? ____

Do you know what caused the problem or what you were doing at the time of injury/start of pain?

☐Fall ☐Trauma ☐Accident ☐ Bending ☐Exercise ☐Housework ☐Lifting
☐Running ☐Working ☐Sports Injury ☐Pregnancy ☐Twisting ☐Sleeping wrong ☐Standing

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

☐ 0-25% (Occasional) ☐ 26-50% (Intermittent) ☐51-75% (Frequent) ☐76-100% (Constant)

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

☐Constant ☐Frequent ☐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?

☐Bending ☐Carrying things ☐Coughing ☐Driving ☐Eating
☐Exercise ☐Going down stairs ☐Heat ☐Housework ☐Ice
☐Jogging ☐Lifting ☐Lying down ☐Massage ☐Most Movements
☐Nothing ☐Pulling ☐Pushing ☐Running ☐Prolonged Sitting
☐Sleeping ☐Sneezing ☐Squatting ☐Standing ☐Prolonged standing
☐Stress ☐Stretching ☐Taking a deep breath ☐Turning ☐Twisting
☐Walking ☐Working ☐Talking ☐Looking up/down ☐Breast/bottle feeding
☐Caring for children ☐Sitting at computer ☐Sitting to Standing ☐Lying to sitting ☐Sitting to lying
☐Lying to standing ☐Bending head ☐Light ☐Allergies ☐Hormonal changes
☐Clenching teeth ☐Grinding teeth ☐Dehydration ☐Lack of Sleep ☐Reading/eye strain
☐Electronic use ☐Caffeine intake ☐Strong Scents ☐Noise ☐Weather Changes

Relieving Factors: What makes the problem better?

☐Nothing ☐Anti-inflammatory ☐Bracing ☐Elevation ☐Exercise ☐Heat ☐Ice
☐Standing ☐Rest ☐Chiropractic Care ☐Massage ☐Movement ☐Pain Killers
☐Stretching ☐Walking ☐Sitting ☐CBD

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

☐Bathing ☐Caring for children ☐Climbing stairs ☐Dressing ☐Yard work ☐Social activities
☐Driving ☐Eating ☐Exercising ☐Sitting to standing ☐Grooming ☐Housework
☐Lifting ☐Lying to sitting ☐Oral Care ☐Shopping ☐Sitting ☐Sleeping
☐Standing ☐Stretching ☐Using technology ☐Walking ☐Watching TV ☐Working
☐Cleaning ☐Cooking ☐Doing Laundry ☐Laying Down ☐Sex ☐Toileting
☐School Work

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

0 1 2 3 4 5 6 7 8 9 10

IF YOU HAVE MORE THAN 2 COMPLAINTS, PLEASE FILL OUT AN ADDITIONAL COMPLAINT FORM

REVIEW OF SYSTEMS

Have or had the following Musculoskeletal symptoms:

☐ Arm/hand pain ☐ Feet/leg pain ☐ Hip 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 ☐ Knee pain ☐ Scoliosis ☐ Fibromyalgia

Have or had the following Cardiovascular/Respiratory symptoms

☐ Cold hands/feet ☐ Cough ☐ Difficulty breathing ☐ Earache/Infections ☐ High cholesterol
☐ Poor hearing ☐ Ringing in ears ☐ High blood pressure ☐ Asthma ☐ Cancer_______

☐ Chest pain, pressure, or discomfort

Have or had the following Head and Neck symptoms

☐ Dizziness ☐ Facial Pain ☐ Grinding/Clenching Teeth ☐ Headache ☐ Migraine ☐ Jaw Clicks ☐ Jaw Pain
☐ Head injury ☐ Swollen Glands ☐ Trouble swallowing ☐ Cancer____________

Have or had the following Nose symptoms:

☐ Allergies ☐ Blocked sinuses ☐ Excessive mucus ☐ Sinus pressure or pain ☐ Stuffiness/blockage ☐ Cancer_____

Have or had the following Urinary symptoms:

☐ Difficulty urinating ☐ Kidney infections ☐ Kidney stones ☐ Unable to hold urine ☐ Frequent UTI ☐ Cancer___

Have or had the following Gastrointestinal symptoms:

☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea ☐ Change in bowel habits ☐ Gall Stones ☐ IBS ☐ Cancer__

Have or had the following Endocrine symptoms:

☐ Cold intolerance ☐ Excessive thirst ☐ Frequent Urination ☐ Heat Intolerance ☐ Sweating ☐ Diabetes

Have or had the following Vascular/Hematologic symptoms:

☐ Calf pain with walking ☐ POTS ☐ Cold hands and feet ☐ Anemia ☐ Ease of bruising ☐ leg cramping ☐ Cancer__

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 ☐ PCOS ☐ Infertility ☐ Endometriosis ☐ Cancer__________

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/Guardian Signature____**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 knowledgably 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.

____ DATE___________________
Patient Signature

____
Printed Name

FOR MINOR PATIENTS ONLY (UNDER 18 YEARS OLD)

Parental Consent for Minor Patient:

Patient Name: ____
Patient age: ___________ DOB: ____________
Printed name of person legally authorized to sign for Patient: ____________________________________
Signature: ____
Relationship to Patient: ____________________

PERMISSION FOR MINOR TO BE SEEN WITHOUT PARENT PRESENT

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 if Dr. Heather is available.
   For an Emergency visit:
   Email 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/debit card and HSA/FSA.

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, 4th 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 for office closures and announcements.

11. Please 'Like' our Facebook Page www.facebook.com/oceansidechiropracticwesterly or follow us on Instagram for additional health information, promotions and announcements.

12. Further office information may also be found at out website www.oceansidechiropractic.net

I have read and understand the above statements.

Patient/Guardian
Signature:____Date:_________________________