

Holland Chiropractic, A Maine Vitality Center (NP)

Today's Date: _____

HRN (Office Use Only): _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

Address: _____ City: _____ State: ____ Zip: _____

E-mail Address: _____ Home Phone: _____ Cell: _____ Work: _____

Appointment reminder: E-mail Text Message None Cell Phone Carrier (for text reminders): _____

Marital Status: Single Married Divorced Widowed Do you have insurance: Yes No Insurance Carrier: _____

Race: American Indian/Alaskan Native Asian Black/African American Caucasian (White) Preferred Language: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Whom shall we thank for referring you? _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1 to 10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Secondary complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

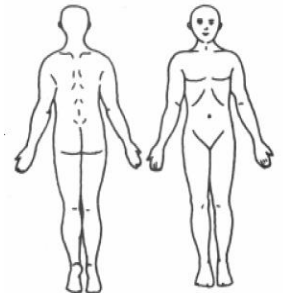
Name of Previous Chiropractor: _____ N/A

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____



LIST RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Is your problem the result of ANY type of accident? Yes No If Yes, please explain: _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes If yes, how many times? _____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: Yes No If yes, please state what type of treatment: _____

Who provided it: _____ How long ago? _____ What were the results: Favorable Unfavorable

Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

| | HOW LONG AGO | TYPE OF CARE RECEIVED | BY WHOM |
|--------------------|--------------|-----------------------|---------|
| INJURIES | → | | |
| SURGERIES | → | | |
| CHILDHOOD DISEASES | → | | |
| ADULT DISEASES | → | | |

SOCIAL HISTORY

1. Smoking: Cigars Pipe Cigarettes How often? Daily Weekends Occasionally Never

2. Alcoholic Beverage: Daily Weekends Occasionally Never

3. Recreational Drug use: Daily Weekends Occasionally Never

4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? No Yes

If yes whom: grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)

Have they ever been treated for their condition? No Yes I don't know

2. Any other hereditary conditions the doctor should be aware of? No Yes: _____

I hereby authorize payment to be made directly to [Holland Chiropractic](#), for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [Holland Chiropractic](#) for any and all services I receive at this office.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

ACTIVITIES OF DAILY LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| ACTIVITIES: | EFFECT: | | | |
|--------------------------|------------------------------------|---|---|--|
| Carry Children/Groceries | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sit to Stand | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Climb Stairs | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Pet Care | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Extended Computer Use | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Lift Children/Groceries | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Read/Concentrate | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Getting Dressed | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Shaving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sexual Activities | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sleep | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Static Sitting | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Static Standing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Yard work | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Walking | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Washing/Bathing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sweeping/Vacuuuming | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Dishes | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Laundry | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Garbage | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Driving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Other: _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

Continued on next page...

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

- | | | | | |
|--|----------------------------|----------------------|------------------------------|--------------------------|
| ___ Headache | ___ Pregnant (Now) | ___ Dizziness | ___ Prostate Problems | ___ Ulcers |
| ___ Neck Pain | ___ Frequent Colds/Flu | ___ Loss of Balance | ___ Impotence/Sexual Dysfun. | ___ Heartburn |
| ___ Jaw Pain, TMJ | ___ Convulsions/Epilepsy | ___ Fainting | ___ Digestive Problems | ___ Heart Problem |
| ___ Shoulder Pain | ___ Tremors | ___ Double Vision | ___ Colon Trouble | ___ High Blood Pressure |
| ___ Upper Back Pain | ___ Chest Pain | ___ Blurred Vision | ___ Diarrhea/Constipation | ___ Low Blood Pressure |
| ___ Mid Back Pain | ___ Pain w/Cough/Sneeze | ___ Ringing in Ears | ___ Menopausal Problems | ___ Asthma |
| ___ Low Back Pain | ___ Foot or Knee Problems | ___ Hearing Loss | ___ Menstrual Problem | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Sinus/Drainage Problem | ___ Depression | ___ PMS | ___ Lung Problems |
| ___ Back Curvature | ___ Swollen/Painful Joints | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disability | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | ___ ADD/ADHD | ___ Eating Disorder | ___ Liver Trouble | |
| ___ Numb/Tingling legs, feet, toes | ___ Allergies | ___ Trouble Sleeping | ___ Hepatitis (A,B,C) | |

MEDICATIONS

Medication Name
(Brand name or generic)

Dosage
(i.e. 5 mg)

Frequency
(i.e. once per day)

| | | |
|--|--|--|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you have any allergies to medications? No Yes If yes, please list the medication(s) and reactions: _____

Patient Signature: _____ **Today's Date:** ___/___/___

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

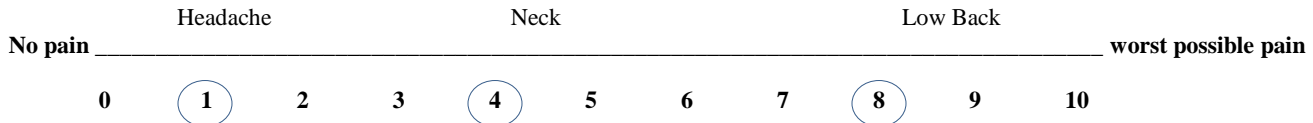
Date _____

PLEASE READ CAREFULLY

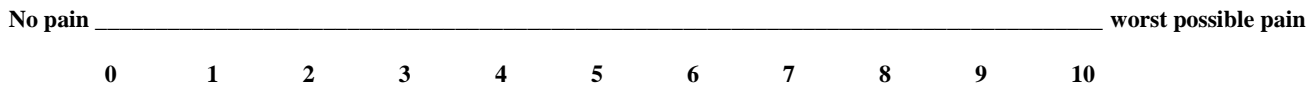
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

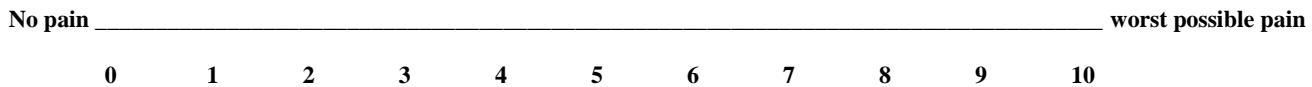
Example:



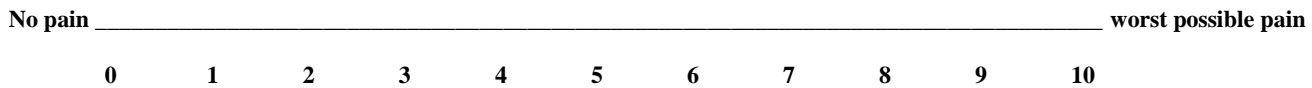
1) What is your pain RIGHT NOW?



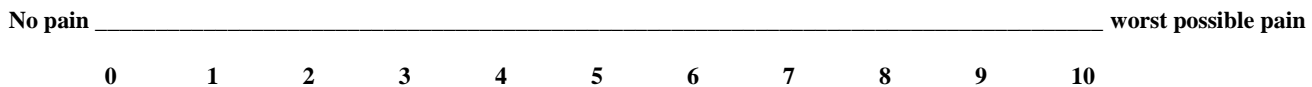
2) What is your TYPICAL or AVERAGE pain?



3) What is your pain level AT ITS BEST? (How close to "0" does your pain get at its best?)



4) What is your pain level AT ITS WORST? (How close to "10" does your pain get at its worst?)



OTHER COMMENTS:

Examiner: _____


Holland Chiropractic

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at [Holland Chiropractic](#) have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ / ____ / ____  *Witness Initials*
Patient or Authorized Person's Signature Date


REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ / ____ / ____  *Witness Initials*
Patient or Authorized Person's Signature Date

Holland Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call [Dr. Rok Morin](tel:207-443-2635) at 207-443-2635 if he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____-retaining page 1 of 2

Holland Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of **Holland Chiropractic** Patient Privacy Notice. I understand my rights as well as the practice’s duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this “Notice of Privacy Practice” at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this “Notice” is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient’s Name DOB HR# (Office Use Only)

Patient’s Signature Date

Witness Date

Holland Chiropractic

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information:

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call my home my work my mobile number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness: _____ Date: _____