SCRANTON CLINIC OF CHIROPRACTIC

CHIROPRACTIC HEALTH QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical healthcare record.

Name (Last, First, M.I.): ☐ M ☐ F	**DOB:**	**Age:**
Street Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed	**Email:**	
Employer:	**Occupation:**	
How did you hear About our office?	**Who can we thank for referring you to our office?**	

HEALTH CONCERNS

What is your main area of pain?	**Origination?** ☐ Gradual ☐ Sudden ☐ Overtime
What is the status of your pain? ☐ New ☐ Reoccurring ☐ Worsened	**When did you first notice the pain?**
What is the level of pain intensity? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 No pain= 0, Mild= 1-3, Moderate= 4-6, Severe= 7-10	
What type of pain do you feel? ☐ Aching ☐ Numbness ☐ Pounding ☐ Tight ☐ Sharp ☐ Other:	
What does this pain stop you from doing?	
How does this complaint make you feel?	**Has it affected your family or work?**
What have you done to treat this pain?	

What are other area's of pain?	**Origination?** ☐ Gradual ☐ Sudden ☐ Overtime
What is the status of your pain? ☐ New ☐ Reoccurring ☐ Worsened	**When did you first notice the pain?**
What is the level of pain intensity? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 No pain= 0, Mild= 1-3, Moderate= 4-6, Severe= 7-10	
What type of pain do you feel? ☐ Aching ☐ Numbness ☐ Pounding ☐ Tight ☐ Sharp ☐ Other:	
What does this pain stop you from doing?	
How does this complaint make you feel?	**Has it affected your family or work?**
What have you done to treat this pain?	
Are there any other area's of concern?	
If this goes untreated what do you think your life will be like?	

HEALTH HISTORY

Growth and Development

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Polio ☐ Excessive High Fever

Please check all that apply:

☐ Chronic Ear Infections	☐ Bronchitis	☐ Pneumonia
☐ Tonsillitis	☐ Sprained/ pulled muscles Where:	
☐ Digestive issues	☐ Broken bones Where:	
☐ Constipation	☐ Other	

List all childhood accidents (minor and serious):

Adult Health

Please check all that apply:

☐ Ear Infections	☐ Bronchitis	☐ Pneumonia
☐ Throat infections	☐ Sprained/ pulled muscles Where:	
☐ Trouble breathing	☐ Broken bones Where:	
☐ Constipation	☐ Gall Bladder problems	☐ Liver problems
☐ Bladder problems	☐ Numbness in arms	☐ Numbness in legs/ feet
☐ High Cholesterol	☐ High Blood Pressure	☐ Chest or Heart pain
☐ Trouble breathing	☐ Rashes or skin allergies	☐ Weight gain
☐ Sinus infections	☐ Trouble sleeping	☐ Low energy levels
☐ Acid Reflux disease	☐ Circulation problems	☐ Excessive flatulence (gas)
☐ Neck or Back pain	☐ Seasonal allergies	☐ Other:

Accidents

Year	Type of Accident	Injury

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ No exercise	☐ Mild exercise	☐ Occasional vigorous exercise	☐ Regular vigorous exercise		
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	What diets or diet plans have you tried?					
	Have you achieved your weight loss goals?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:			
Date of last menstruation:	Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____			
Are you pregnant or breastfeeding?		☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?		☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?		☐ Yes	☐ No
Any blood in your urine?		☐ Yes	☐ No
Any problems with control of urination?		☐ Yes	☐ No
Any hot flashes or sweating at night?		☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
- Health: A state of optimal physical, mental and social well- being, not merely the absence of disease and 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 to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, 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 prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All x-rays and exams performed will be analyzed by a chiropractic physician in this clinic with a report of findings given as soon as possible. It is understood that any discounted x-rays will remain in your personal health file at this clinic and not be released to other healthcare facilities until full cost is received.

I have read and fully understand and agree to the above statements. _____ _____

Signature Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period:_____

_____ _____

Signature Date

Who do you authorize us to speak with about your care in this office?

Name_____ Relationship _____ Phone number _____ (revoked)

Name_____ Relationship _____ Phone number _____ (revoked)

Name_____ Relationship _____ Phone number _____ (revoked)

Scranton Clinic of Chiropractic

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but the acknowledgment could not be obtained because

☐ Individual refused to sign ☐ Communications barriers prevented us from obtaining acknowledgment

☐ An emergency prevented us from obtaining acknowledgement ☐ Other: _____

Scranton Clinic of Chiropractic **Notice Of Privacy Practices** Patient Copy

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 18, 2015, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so by listing their names as authorized members.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or e-mails).

Sign-In Log: The office maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's in the office suite. This information may be seen by, and is accessible to, others who are seeking care in this office.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $20.00 per hour (with a minimum of $20.00) for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. Contact Officer: Dr. Robert Scranton. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Robert Scranton Address: 4775 W. Daybreak Parkway. South Jordan UT 84095 Telephone: (801) 571-1338