HEALTH PROFLIE

Today's Date: / / ID# : _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: / / Age: _____ ○ Male ○ Female

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

E-Mail Address: _____ Home Phone: _____ Cell: _____

Marital Status: ○ Single ○ Married Do you have Insurance ○ Yes ○ No Height: _____ Weight: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Relation to Emergency Contact: _____

Name of Emergency Contact: _____ Phone Number: _____

Permission to share medical information with emergency contact: ○ Yes ○ No

Number of Children: _____ Names, Ages and Gender: _____

Whom may we thank for referring you to our office? _____

LIST YOUR HEALTH CONCERNS BELOW

Primary _____ When Did it start? _____ **Second** _____ When did it start? _____

Third _____ When did it start? _____ **Forth** _____ When did it start? _____

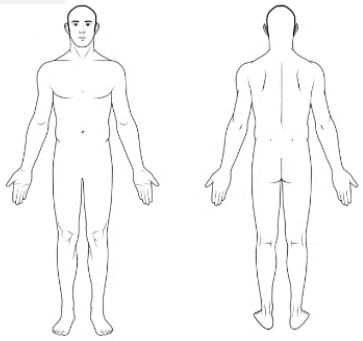
On a scale of 1-10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number.

Primary or Chief complaint is:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Second complaint is:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Third complaint is:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Forth complaint is:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

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

R= Radiating **B= B**urning **D= D**ull **A= A**ching **N= N**umbness

S= Sharp/**S**tabbing **T= T**ingling



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 health concern start? ○ Suddenly ○ Gradually ○ Unknown ○ Post-Injury

If started with an injury explain: _____

Condition(s) ever been treated by anyone in the past? ○ NO ○ YES If yes, when: _____ by who: _____

What relieves your symptoms: _____

What makes symptoms worse: _____

CHIROPRACTIC HISTORY

Have you ever seen a Chiropractor before? ◯ YES ◯ NO Last visit: _____ Name: _____

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other: _____

What would you like to gain from chiropractic care? ◯ Resolve existing condition(s) ◯ Overall Wellness ◯ BOTH

Please CHECK PAST problems and CIRCLE CURRENT problems

Headache	Infertility	Dizziness	Prostate Problems	Ulcers
Neck pain	Frequent Colds/Flu	Loss of Balance	Impotence/Sexual Disfunction	Heartburn/Gastric Reflux
Jaw Pain/TMJ	Convulsions/Epilepsy	Fainting	Digestive Problems/IBS	Heart Problem
Shoulder Pain	Tremors/Tics	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 or Sneeze	Ringing in Ears	Menopausal Problems	Difficulty Breathing
Low Back Pain	Sinus/Drainage Problems	Depression	PMS	Lung Problems
Hip Pain	Foot or Knee Problems	Hearing Loss	Menstrual Problem	Kidney Trouble
Sciatica	Swollen/Painful Joints	Irritable	Bed Wetting	Gall Bladder Trouble
Scoliosis	Skin Problems	Mood Changes	Learning Disability	Ear Infections
Pain/Numb/Tingling in Arms/Hands/Fingers	ADD/ADHD	Eating Disorder	Liver Trouble	Thyroid Problems
Pain/Numb/Tingling in Legs/Feet/Toes	Allergies	Trouble Sleeping	Hepatitis (A,B,C)	Nervousness
Fibromyalgia	Brain Fog	Lupus	Anxiety	Chronic Fatigue
OTHER:_____	_____	_____	_____	

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 _____ Cancer _____Rheumatoid Arthritis _____ Osteoarthritis

_____ Scoliosis _____ Heart Attack/Heart Disease _____ Stroke _____ Diabetes I or II _____ Seizures _____ Spinal Surgery

_____ Other Serious Conditions/ Surgeries: _____

FAMILY HISTORY

Does anyone in your family suffer from the same condition(s) you do? ◯ Yes ◯ No If yes, whom?

◯ Grandmother ◯ Grandfather ◯ Mother ◯ Father ◯ Sister ◯ Brother ◯ Daughter ◯ Son

Which condition(s): _____

Have they ever been treated for their condition ◯ Yes ◯ No ◯ Unsure

Any other hereditary conditions the doctor should be aware of that run in your family? ◯ Yes ◯ No

If yes, please explain: _____

CHIROPRACTIC FOCUSED HISTORY

YOUR HEALTH GOALS

List the top 2 health goals that YOU would like to accomplish this year;

1. _____
2. _____

TRAUMAS: Physical Injury History

Notable childhood injuries? ○ Yes ○ No ***If yes, Please explain***: _____

Youth or college sports? ○ Yes ○ No ***If yes, list major injuries***: _____

Have you ever had any significant falls, surgeries, or other injuries? ○ Yes ○ No

If you were in a RECENT accident, what type of accident was it? ○ Personal Injury ○ Motor Vehicle Accident ○ Work Injury

Please explain:_____

Exercise Frequency? ○ None ○ 1-2x/week ○ 3-5x/week ○ Daily

How do you normally sleep? ○ Back ○ Side ○ Stomach

Do you wake up: ○ Refreshed and ready ○ Stiff and tired ○ Other: _____

Average hours spend sleep at a time? ○ <1 hour ○ 1-2 hrs ○ 2-3hrs ○ 3-4hrs ○ 4-5hrs ○ 5-6hrs ○ 6+hrs

Do you commute to work? ○ Yes ○ No ***If yes, how many minutes per day?*** _____

List any problems with flexibility (ex. Putting on shoes/socks, etc…) _____

How many combined HOURS / DAY do you typically spend sitting at a desk, on a computer, tablet or phone? _____

TOXINS: Chemical & Environmental Exposure

☆ **If you consume any of the following, please indicate how often (select ALL that apply for each item below):**

	Last 48 Hrs	Daily	Weekends	Occasionally	Never		Last 48 Hrs	Daily	Weekends	Occasionally	Never
Alcohol						Caffeine					
Sugar						Cigarettes					
Artificial Sweeteners						Cigars					
Sugary Drinks						Pipe Tobacco					
Dairy						Recreational Drugs					
Processed Foods											

☆ **Please list any medication(s) / Vitamins / Herbs / other that you are taking:** *If taking more than what is listed above, please list on a separate blank sheet of paper.

MEDICATION | SUPPLEMENT: DOSAGE: FREQUENCY TAKEN: PURPOSE FOR TAKING:

1. _____
2. _____
3. _____
4. _____
5. _____

THOUGHTS: Emotional Stresses & Challenges

☆ Please rate your STRESS level for each:

	NONE		MODERATE		HIGH			NONE		MODERATE		HIGH	
Home	0	1	2	3	4	5	**Money**	0	1	2	3	4	5
Work	0	1	2	3	4	5	**Health**	0	1	2	3	4	5
Life	0	1	2	3	4	5	**Family**	0	1	2	3	4	5

ACTIVITIES OF LIFE

Please identify how your current condition(s) affect your ability to carry out activities that are routinely part of your life (SELECT WHAT APPLIES)

Carry Children/Groceries	Painful (can do)	Painful (limits)	Unable to Perform
Sit to Stand	Painful (can do)	Painful (limits)	Unable to Perform
Climb Stairs	Painful (can do)	Painful (limits)	Unable to Perform
Pet Care	Painful (can do)	Painful (limits)	Unable to Perform
Extended Computer Use	Painful (can do)	Painful (limits)	Unable to Perform
Read/Concentrate	Painful (can do)	Painful (limits)	Unable to Perform
Getting Dressed	Painful (can do)	Painful (limits)	Unable to Perform
Shaving	Painful (can do)	Painful (limits)	Unable to Perform
Sexual Activities	Painful (can do)	Painful (limits)	Unable to Perform
Sleep	Painful (can do)	Painful (limits)	Unable to Perform
Static Sitting	Painful (can do)	Painful (limits)	Unable to Perform
Static Standing	Painful (can do)	Painful (limits)	Unable to Perform
Yard Work	Painful (can do)	Painful (limits)	Unable to Perform
Walking	Painful (can do)	Painful (limits)	Unable to Perform
Washing/Bathing	Painful (can do)	Painful (limits)	Unable to Perform
Sweeping/Vacuuming	Painful (can do)	Painful (limits)	Unable to Perform
Dishes	Painful (can do)	Painful (limits)	Unable to Perform
Laundry	Painful (can do)	Painful (limits)	Unable to Perform
Garbage	Painful (can do)	Painful (limits)	Unable to Perform
Driving	Painful (can do)	Painful (limits)	Unable to Perform
Other:	Painful (can do)	Painful (limits)	Unable to Perform

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

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 risks are most often very minimal, 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 **Rhino 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 herby consent to treatment by any means, method, and or techniques, the doctor deem necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ ____ / ____ / ____ _____
Patient Name (PRINT) Patient or Authorized Person's Signature Date Rhino Initials

REGARDING: X-rays/Imaging Studies

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.

THIS LINE IS FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff 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.

_____ _____ ____ / ____ / ____ _____
Patient Name (PRINT) Patient or Authorized Person's Signature Date Rhino Initials

REGARDING: Authorization of Payment for Services Rendered

I hereby authorize payment to be made directly to **RHINO 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 **RHINO CHIROPRACTIC** for any and all services receive at this office.

_____ _____ ____ / ____ / ____ _____
Patient Name (PRINT) Patient or Authorized Person's Signature Date Rhino Initials

REGARDING: Rhino Chiropractic Notice of Right to Privacy

Patient Initials: _____ - **Page 6 was retained**

I have received a copy of Rhino 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 Name (PRINT) Patient or Authorized Person's Signature Date Rhino Initials

_____ ____ / ____ / ____
Doctor Signature Date

RHINO CHIROPRACTICE 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 **P**ersonal **H**ealth **I**nformation. 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 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 to our front desk receptionist. Keep this page for your records.

PREMITTED 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 – to prevent or lessen a serious or imminent threat to the health or safety of a person or 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 purpose.
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 apprize 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 from 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 Ryan Mulcahy** at **(585)420-7926**. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days.

RHINO CHIROPRACTIC
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VICTOR NY 14564
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