

**Frederick Chiropractic Wellness Center, Inc.**

425 E Patrick St. Frederick, MD 21701

301-695-0032

**PATIENT INFORMATION**

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

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Sex M F SSN \_\_\_\_\_ Email Address \_\_\_\_\_

Marital Status S M D W Spouse's Name \_\_\_\_\_ # of children \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Preferred method of contact? H W C Email

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation/Job Duties \_\_\_\_\_

Primary Care Dr \_\_\_\_\_ Address \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Insurance Information**

Do you have health insurance? Yes No

Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Do you have additional insurance? Yes No

Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I understand and agree that all services/treatments rendered to me or my dependents by Dr. Deborah Morrone and Frederick Chiropractic Wellness Center, Inc. are charged directly to me and that I am personally responsible for payment. I authorize this office to release any medical information and to complete any reports and forms to assist in collecting from my insurance carrier. I authorize the use of this signature on all insurance submissions. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will immediately become due and payable. I understand that this office does not file for or accept assignment for secondary insurance coverage (except for Medicare), and I may be provided with receipts for further reimbursement upon request.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature (for a minor) \_\_\_\_\_ Date \_\_\_\_\_

**Patient Authorization**

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care or relationship with Frederick Chiropractic Wellness Center, Inc. *By initialing below, you authorize the following:*

\_\_\_\_\_ Appointment Reminders and Scheduling Related Matters: This office may use your contact information for the purpose of appointment reminders, or other health care and scheduling related matters.

\_\_\_\_\_ Contact Regarding Chiropractic and Health Related Information: This office may use your contact information for the purpose of advising you about health related meetings, workshops, and products. You will also be placed on our mailing list for our bi-monthly e-newsletter. (You may unsubscribe to the newsletters anytime by going to [www.FrederickChiro.com](http://www.FrederickChiro.com).)

\*\*Your information will never be shared with 3<sup>rd</sup> parties (except as required by law, or as otherwise authorized), and you may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow up to 30 days for change in our system to be completed.

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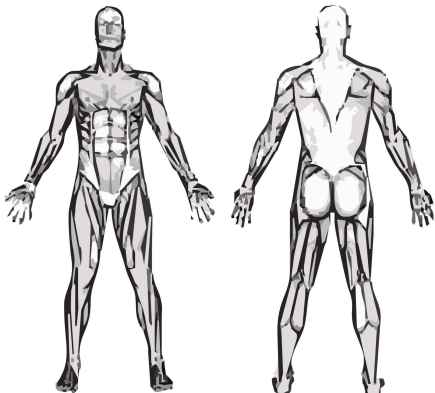
301-695-0032

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

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

**Health History**



Please mark **ALL** areas of concern, and use the following letters to show **TYPE** and **LOCATION** of the symptoms you are experiencing.

A=Ache    B=Burning    P=Pins/Needles    M= Muscle spasm    N=Numbness  
S=Sharp    T= Tight

What is your primary health concern? \_\_\_\_\_

When did it begin? \_\_\_\_\_

What do you think caused this problem? \_\_\_\_\_

Has your condition gotten: More severe    Less severe    More frequent    Less frequent    No change

What makes it worse? Sitting    standing    walking    running    sleeping    lying down    lifting    bending  
exercising    resting    changing positions    stretching    lifting    Other \_\_\_\_\_

What makes it better? Sitting    standing    walking    running    sleeping    lying down    lifting    bending  
exercising    resting    changing positions    stretching    lifting    Other \_\_\_\_\_

When does it bother you most? AM    PM    during activity    after activity    at rest    while sleeping

What activities does this limit you from doing or enjoying? \_\_\_\_\_

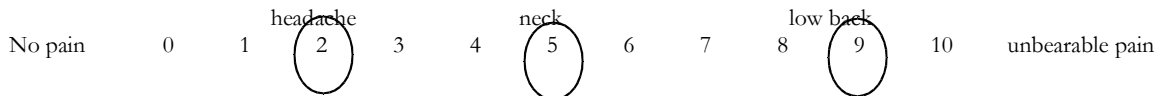
What other treatment have you received for your condition? Medication    Surgery    Chiropractic  
Physical Therapy    Massage    Acupuncture    None    Other \_\_\_\_\_

Have you had this problem before? Yes    No    When? \_\_\_\_\_

**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 average pain levels and pain at minimum/maximum over the past 3 months. If you have completed this form before, indicate you average pain level since the last time you completed this form.

**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)?



What % of your awake hours is your pain at its best?    0    10    20    30    40    50    60    70    80    90    100%

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



What % of your awake hours is your pain at its worst?    0    10    20    30    40    50    60    70    80    90    100%

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The more we know about your unique health history, the better we can help you. Please fill out the information below as completely as possible. Please note any of the following conditions you have or have had in the past (C = Currently, P = Past).

- \_\_\_ AIDS/HIV \_\_\_ Alcoholism \_\_\_ Allergies \_\_\_ Anemia \_\_\_ Anxiety/Depression
\_\_\_ Arthritis \_\_\_ Asthma \_\_\_ Bleeding disorders \_\_\_ Breast lumps \_\_\_ Bronchitis
\_\_\_ Cataracts \_\_\_ Constipation/Diarrhea \_\_\_ Cancer \_\_\_ Chemical dependency \_\_\_ Chest pain
\_\_\_ Diabetes \_\_\_ Dizziness/Vertigo \_\_\_ Emphysema \_\_\_ Epilepsy \_\_\_ Fatigue
\_\_\_ Fractures \_\_\_ Frequent Colds/Flu \_\_\_ Gout \_\_\_ Heart disease \_\_\_ Hernia
\_\_\_ Herniated disc \_\_\_ High cholesterol \_\_\_ Joint replacement \_\_\_ Kidney infection \_\_\_ Liver disease
\_\_\_ Migraines \_\_\_ Miscarriage \_\_\_ Mononucleosis \_\_\_ Sleep problems \_\_\_ Tension Headache
\_\_\_ Thyroid problems \_\_\_ Tonsillitis \_\_\_ Tumors \_\_\_ Ulcers \_\_\_ Vaginal infections

Please list any other health concerns you have or have had \_\_\_\_\_

Please list all past surgeries and dates \_\_\_\_\_

Please list all past accidents/injuries and dates \_\_\_\_\_

Have you ever been under Chiropractic care? Y N Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

Have you been treated for any health condition in the past year? Yes No Details \_\_\_\_\_

Are you currently under the care of any other physician? Y N Date of last physical exam \_\_\_\_\_

Dr's Name/Location? \_\_\_\_\_

What medications are you taking (note dosage and duration) \_\_\_\_\_

What vitamins/supplements are you taking? \_\_\_\_\_

How would you rate the following:

Family Stress None 1 2 3 4 5 6 7 8 9 10 Severe

Job Stress None 1 2 3 4 5 6 7 8 9 10 Severe

Overall Health Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Sleeping Excellent Good Fair Poor # of hours \_\_\_\_\_ Do you feel rested when you wake? Y N

Do you regularly consume:

- Caffeine none light moderate heavy Sugary foods none light moderate heavy
Alcohol none light moderate heavy Artificial Sweeteners none light moderate heavy
Water none light moderate heavy Fruits/Vegetables none light moderate heavy
Processed food none light moderate heavy Soda none light moderate heavy
'Diet' foods none light moderate heavy Tobacco none light moderate heavy

Do you limit any of the following from your diet? Fat Cholesterol Salt Wheat/Gluten Dairy Sugar/Carbs Other \_\_\_\_\_

Do you exercise? Yes No How often? 1-2 x/week 3-4x/week more than 5x/week

Types of activity \_\_\_\_\_

What health improvements would you most like to make? (Choose top 3)

- ( ) Overall health and fitness ( ) Nutrition ( ) Exercise ( ) Better sleeping ( ) Stress management
( ) Reduce/eliminate medication use ( ) Strengthening ( ) Flexibility ( ) Pain management ( ) Avoid surgery
( ) Weight loss Other \_\_\_\_\_

Is there any other information that you think may be pertinent to your health care in this office?

I verify that the health information provided above is accurate and complete.

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Our practice has the right to accept or deny your request.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure.

You may inspect and receive copies of your records within 30 days of a written request. There may be a reasonable cost-based fee for photocopying, postage and preparation.

**You may request changes to your records, in writing. Our practice has the right to accept or deny your request.**

We maintain a history of protected health information disclosures that is accessible to you upon written request. Such requests will be fulfilled within 60 days.

In the future, we may contact you to provide appointment reminders or information about treatment alternatives, or other health-related benefits and services that may be of interest you.

You have the right to request confidential communications by alternative means or to an alternative location (i.e., you may request that you be contacted in a specified place or manner).

### **Notice regarding chiropractic care being provided in an “open-door” adjusting environment**

It is the desire of this office to provide chiropractic care in an “open-door” adjusting environment. An “open-door” approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. 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. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open door” environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

If you choose not to be adjusted in an open-door adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care or on your relationship with our staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

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I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Patient or legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature (office staff)

\_\_\_\_\_  
Date

**PATIENT AUTHORIZATION**

**OTHERS INVOLVED IN MY HEALTHCARE**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Frederick Chiropractic Wellness Center, Inc. and Dr. Deborah Morrone *MAY discuss* all aspects of my healthcare with:

_____ Print Name	_____ Relationship
_____ Print Name	_____ Relationship
_____ Print Name	_____ Relationship

As the patient, you may also request that any part of your Private Health Information (PHI) NOT be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

Frederick Chiropractic Wellness Center, Inc. and Dr. Deborah Morrone *MAY NOT discuss* my healthcare with:

_____ Print Name	_____ Relationship
_____ Print Name	_____ Relationship
_____ Print Name	_____ Relationship

\_\_\_\_\_  
Signature of Patient or Legal Representative

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

\*\*You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow up to 30 days for change in our system to be completed.

Thank you!