Cafe of Life Chiropractic
NEW PATIENT INFORMATION FORM

Please print clearly:

Name_____ Date_____

Address_____Apt.# _____

City _____ State_____ ZIP _____

Shipping Address (if different)_____

Home Phone (_____) _____-_____Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Social Security # _____

E-mail address: _____

REFERRED BY:_____

Occupation_____ Employer _____

Date of Birth: _____ Age _____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

_____

_____

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use separate sheet if needed): _____

_____

Medications you take: [] Nerve Pills [] Pain Killers [] Muscle Relaxers [] Birth Control

[] AntiDepressants [] Tranquilizers [] Insulin [] Blood Sugar Pills [] High Blood Pressure

[] Aspirin/Tylenol [] Others: _____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit): _____

_____

Name: _____ Date _____

Nutritional supplements you are taking: _____

_____

_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes(per day) _____Coffee(cups per day)_____Alcohol(drinks per week)_____

HISTORY:

Have You ever had any of the following diseases or conditions:

[]Heart Attack/Stroke	[] Heart Surgery/Pacemaker	[] Heart Murmur
[] Congenital Heart Defect	[] Mitral Valve Prolapse	[] Artificial Valves
[] Alcohol/Drug Abuse	[] Venereal Disease	[] Hepatitis
[] HIV+/Aids	[] Shingles	[] Cancer
[] Frequent neck pain	[] Emphysema	[] Anemia
[] High/Low Blood Pressure	[] Psychiatric Problems	[] Rheumatoid Fever
[] Severe/Freq. Headaches	[] Kidney Problems	[] Ulcers/Colitis
[] Fainting/Seizure/Epilepsy	[] Sinus Problems	[] Asthma
] Diabetes/Tuberculosis	[] Difficulty Breathing	[] Chemotherapy
[] Lower Back Problems	[] Artificial Bones/Joints	[] Arthritis

Have you Ever: [] Knocked Unconscious [] Treated for a spine disorder [] Fractured bone [] List any surgery or operations with approx. date: _____

_____

_____

Past Accidents or injuries:_____

_____

Major FallsChildhood:_____

_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other_____

Name: _____ **Date** _____

Marital Status: S M D W DP **Name of Spouse**_____

Describe health of spouse: _____ Number of children if any _____

List any physical conditions or concerns for each:

Name of Child/Spouse	Age	Sex	Condition
_____	___	M/F	_____
_____	___	M/F	_____
_____	___	M/F	_____
_____	___	M/F	_____
_____	___	M/F	_____

Are You Vegetarian? Y / N If so, to what degree? _____

Do you have any religious/or other dietary restrictions and if so what are they?_____

_____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

Name of Emergency Contact: _____ **Relation:** _____
Number of Emergency Contact: _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor. I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. ***Payment is due in full at time of treatment unless prior arrangements have been approved.***

SIGNED:_____ **DATE:** _____

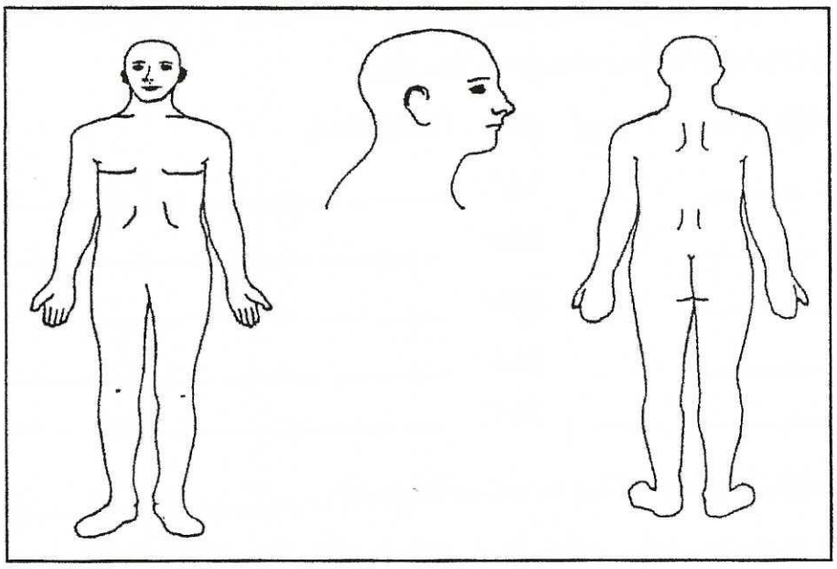
Pregnancy Release

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 x-ray can be hazardous to an unborn child. Date if last menstrual period:

_____ _____

Signature Date

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?
On a scale of 1 to 10, 10 being the worst possible pain how would you rate it today?

1. _____Pain/Stiffness/Numbness Rating_____
2. _____Pain/Stiffness/Numbness Rating_____
3. _____Pain/Stiffness/Numbness Rating_____
4. _____Pain/Stiffness/Numbness Rating_____

When do you think these problems originally started?

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

This issue affects my (please circle what applies):
Job, Childcare, Marriage, Sex, Golf, Finances, Playing with my kids, Bowels, Urine, Mood, Exercise, School.

Please give the Doctor any additional conditions or situations that you might also be dealing with other then the problem mentioned above. Please include all current health issues._____
_____
_____
_____
_____

Notice of privacy for:
Patients Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy:

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Workers Compensation or No Fault to verify that treatment has been rendered.
- To determine patients benefits in a healthcare plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business Associates providing written assurances for your privacy have been obtained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-in logs may be disclosed to verify office visits.
- To send out birthday cards, postcards, reminders, or newsletters.
- We have open treatment arrangement to keep office flow efficient so that you can be serviced in timely manner.
- With consent to use your success story for advertising purposes, whether print, audio, video, or world wide web.

Any other uses or disclosures will only be made with your specific written prior authorizations.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is Lisa and can be reached at Gucciardo Specific Chiropractic regarding privacy issues.
- Inspect, copy, and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer.

This office reserves the right to change the terms of this notice and make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient	Signature of Patient or Legal Representative	Date

Welcome to the Café of Life!

TERMS OF CASE 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.

Adjustments: An adjustment is the specific application of forces to facilitate the body's connection of vertebral subluxation. My chiropractic method of connection is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or 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.

I 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, I encounter non-chiropractic or unusual findings, I will advise you. If you desire advice, diagnosis or treatment of those findings, I will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. My ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. My only method to eliminate this interference is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statement.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(signature) (date)

Consent to Evaluate and Adjust a Minor Child

I, _____being the parent or legal guardian of_____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

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 x-ray can be hazardous to an unborn child.

End of last menstrual period: _____/____/____

_____ _____

(signature) (date)

Café of Life Health Care Authorization Form

Name:_____

SS #_____Date of Birth_____

THE PERSON IDENTIFIED ABOVE AUTHORIZES THE DOCTORS AT THE CAFÉ OF LIFE TO USE AND OR DISCLOSE PROTECTED HEALTH (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

1. I give permission to the Doctors at the Café of Life to use my address, phone number and clinical records to contact me with appointment reminders, missed reservation notification, birthday cards, holiday related cards, information about treatment alternative or other health related information.
2. If the Café of Life contacts me by phone, I give permission to leave a phone message on my answering machine or voicemail.
3. I give the Café of Life 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 PHI during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations. I also consent to signing the guest book and understand it may be viewed by others.
4. By signing this form you are giving Café of Life permission to use and disclose your PHI in accordance with the directives listed above.
5. I authorize my insurance company to pay to the chiropractor or chiropractic group on all insurance submissions.
6. I authorize the chiropractor to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

EXPIRATION

The Authorization shall expire on the following date:_____

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 and delivering a written notice to the Privacy Official of the Café of Life. The written notice must contain the following information:
Your Name, Social Security #, 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 the Café of Life receives it.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, the Café of Life will not refuse treatment. You have a right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

Print Name of Patient_____

Signature of Patient_____

Date_____

Signature of Personal Representative_____