HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restriction.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ Yes ☐ No

May we leave a message on your answering machine or on your cell phone? ☐ Yes ☐ No

May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Informed Consent to Treat

Thank you for trusting Sycamore Chiropractic and Nutrition with your health! We provide functional medicine counseling, nutritional counseling, chiropractic care, and massage therapy. Because you have chosen to engage one or more of these modalities, we ask you to sign this consent form:

I hereby request and consent to the performance of nutritional therapy and counseling, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy (including but not limited to massage therapy, muscle stimulation, ultrasound, and stretching), and diagnostic X-rays on me and my family members (or on the patient named below for whom I am legally responsible) by Dr. David Boynton, DC, CCEP, or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss my health care needs and the nature and purpose of chiropractic adjustments and other procedures and counseling with Dr. Boynton, DC, CCEP and/or with other office or clinic personnel. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely upon the doctor to exercise judgment, based upon the facts then known to him or her, in providing treatment which the doctor feels is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I agree if I am pregnant or trying to get pregnant that I will inform the doctor immediately.

Patient Printed Name: _____ Date: _____

Patient Signature: _____

Consent to treat a Minor

[circle one]

I _____ (Mother, Father, Guardian) give permission to Sycamore Chiropractic and Nutrition to treat my son or daughter or legal dependent. I understand that I do not have to be present with them for every visit.

I understand that I am responsible for all charges that are associated with treatment of the minor for whom I am responsible.

Signature of Parent or Guardian: _____ Date: _____

New Chiropractic Patient Intake Form

Patient's Name: _____

Signature: _____

Today's Date: _____ Date of Birth:____/____/_____ Age:_____ Gender: ☐ M ☐ F

Address: _____

City: _____ State: _____ Zip Code: _____

Marital status:_____ Cell Phone:_____ Home Phone: _____

Email: _____

Highest Education Level: ☐ High School ☐ Under-Graduate Degree ☐ Post-Graduate Degree

Job Title: _____ Hours per week: _____

Nature of Business: _____

Genetic Background: Place a check mark next to your selection(s).

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Mediterranean

☐ Native American ☐ Northern European ☐ Other: _____

Emergency Contact

Name:_____ Relationship:_____ Telephone:_____

How did you hear about our office? _____

Height and Weight

Height (feet/inches):	Current weight:
Usual weight +/- 5 lbs:	Desired weight range:
Highest adult weight:	Lowest adult weight:
Weight fluctuations (>10 lbs):	Body fat % (if known):

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Current Complaints and Concerns

List in a few words the main problems you are having or the purpose for your consultation

1. _____

2. _____

3. _____

Please rate your overall health: Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

Please rate your energy levels: Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

Please elaborate on your condition below:

How long ago did your symptoms begin? _____

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
EX: *Headache*	*May 2006*	*2 times per week*	*Acupuncture, Aspirin*	*Mild improvement*

What types of treatments have you received for your symptoms and have they been helpful?

What seems to make you feel worse (certain movements, weather changes, etc.)?

_____

What seems to make you feel better?

_____

If you could make only one improvement in your health, what would it be?

_____

Are you currently in pain? ☐ Yes ☐ No Is your pain due to an injury? ☐ Yes ☐ No

If yes, please describe the injury and the date it occurred:

If no, please describe how long you have had this pain and what you believe it is caused by:

Please list all of the areas where you currently have pain

Location: ***Ex. Abdomen*** Orientation: ***Ex***. ***Right upper*** Type: ***Ex. Aching*** Severity: ***Ex. Mild***

Location: _____ Orientation: _____ Type: _____ Severity: _____

Location: _____ Orientation: _____ Type: _____ Severity: _____

Location: _____ Orientation: _____ Type: _____ Severity: _____

Location: _____ Orientation: _____ Type: _____ Severity: _____

Location: _____ Orientation: _____ Type: _____ Severity: _____

Please list all medications and supplements you are currently taking

Medication or Supplement	Dose	Frequency	Length of time taking it	Reason for taking it
Ex: Ibuprofen	***400 mg***	***2 X a day***	***1 week***	***Knee injury***

Medical History

Current or past medical conditions (list date of diagnosis or onset) ☐ **None**

Accidents or Major Trauma / Injuries (list month and year) ☐ **None**

Surgeries/Hospitalizations (list month, year, reason) ☐ **None**

Have you ever had a cosmetic surgery (explain)? _____

Family Medical History

List any major illnesses for each family member. If deceased, give cause of death and age at death.

Mother: _____

Father: _____

Maternal grandparents: _____

Paternal grandparents: _____

Brothers/sisters: _____

Please list any other complaints or information not previously mentioned

Blood Type: ☐ **A-** ☐ **A+** ☐ **B-** ☐ **B+** ☐ **AB-** ☐ **AB+** ☐ **O-** ☐ **O+** ☐ **Unknown**

Symptoms Review

General

Never	Past	Ongoing	
☐	☐	☐	Aches / Pains, sensitive to touch
☐	☐	☐	General Weakness
☐	☐	☐	Cold Hands and Feet
☐	☐	☐	Often Fatigued or Exhausted
☐	☐	☐	Difficulty Falling/Staying Asleep
☐	☐	☐	Nightmares
☐	☐	☐	No Dream Recall
☐	☐	☐	Daytime Sleepiness
☐	☐	☐	Sleep less than 8 hours a night
☐	☐	☐	Need caffeine to really wake up
☐	☐	☐	Feel unrefreshed upon waking
☐	☐	☐	Worn out by little effort
☐	☐	☐	Feel worse standing, legs heavy
☐	☐	☐	Considered sickly or in poor health
☐	☐	☐	Hands tremble slightly for no reason
☐	☐	☐	Balance problems

Lower Back

Never	Past	Ongoing	
☐	☐	☐	Sciatica - pain radiating down leg(s)
☐	☐	☐	Bulging or herniated disc
☐	☐	☐	Bowel problems (constipation, etc.)
☐	☐	☐	Numbness or tingling in the legs
☐	☐	☐	Foot drop
☐	☐	☐	Any previous or ongoing diagnosis?

Neck

Never	Past	Ongoing	
☐	☐	☐	Stiffness
☐	☐	☐	Lumps or swelling
☐	☐	☐	Neck glands swell
☐	☐	☐	Goiter

Head / Neurological

Never	Past	Ongoing	
☐	☐	☐	Poor Concentration / Focus
☐	☐	☐	Confusion
☐	☐	☐	Mental Sluggishness / Brain Fog
☐	☐	☐	Forgetfulness / Poor Memory
☐	☐	☐	Indecisive
☐	☐	☐	Head feels heavy
☐	☐	☐	Hair loss or turned gray prematurely
☐	☐	☐	Hair dry or brittle
☐	☐	☐	Face Twitch
☐	☐	☐	Numbness / Tingling anywhere
☐	☐	☐	Dizziness
			Headaches (check ones below)
			☐ Frequent ☐ Occasional
			☐ Severe ☐ Moderate ☐ Mild
			☐ Front of head ☐ Back of head
			☐ Mornings ☐ Afternoons
☐	☐	☐	Concussion / Whiplash

Musculoskeletal

Never	Past	Ongoing	
☐	☐	☐	Weakness in arms and/or legs
☐	☐	☐	Injure, sprain, or strain easily
☐	☐	☐	Sharp, shooting, throbbing pains
☐	☐	☐	Morning stiffness
☐	☐	☐	Back pain
☐	☐	☐	Damp weather bothers you
☐	☐	☐	Cramps or spasms
☐	☐	☐	Aching muscles not due to exercise
☐	☐	☐	Favor one side when sitting/walking
☐	☐	☐	Difficulty bending down
☐	☐	☐	Difficulty reaching overhead
☐	☐	☐	Joint swelling, pain, stiffness
☐	☐	☐	Restless legs at night

Nutritional History

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Do you read food labels? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

The most important thing I should change about my diet to improve my health is _____

_____

Do you currently follow any particular diet or nutritional program? ☐ Yes ☐ No

☐ Gluten-Free ☐ Low-Carb ☐ Dairy-Free ☐ Vegetarian ☐ Blood Type ☐ Other

How many servings of fruits and vegetables do you eat per day? _____

What types of beverages do you consume? _____

How much water do you drink daily? _____

Do you have symptoms immediately after eating? ☐ Yes ☐ No

Specify symptoms and any associated foods: _____

When you miss meals or go without food for extended periods of time, do you feel weak, dizzy, hangry, irritable, or weak (explain)? _____

Frequency of bowel movements (daily or weekly)? _____

Lifestyle History

Do you currently smoke? ☐ Yes ☐ No

Are you frequently exposed to second hand smoke? ☐ Yes ☐ No

Rate your history of alcohol intake: ☐ None ☐ Mild ☐ Moderate ☐ High

How many drinks do you consume per week? (*1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*)

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Average number of hours you sleep per night? ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you exercise regularly? ☐ Yes ☐ No Do you have a sedentary job? ☐ Yes ☐ No

Current exercise program? _____

Rate your level of motivation for including exercise in your life: ☐ Low ☐ Medium ☐ High

List problems that limit activity: _____

Are you extra tired after exercise? ☐ Yes ☐ No Do you sweat when exercising? ☐ Yes ☐ No

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Are you happy overall? ☐ Yes ☐ No

Hobbies and Leisure activities: _____

Environmental

In your work or home environment, are you exposed to:

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold ☐ Radon ☐ Medical Radiation

How many hours a day do you spend on a cell phone? _____ On a computer? _____

Do you notice any symptoms related to electronic device exposure (specify)? _____

Which of these significantly affect you? Check all that apply.

☐ Cigarette smoke ☐ Perfumes/Colognes ☐ Auto exhaust fumes ☐ Other:

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Lead ☐ Mercury ☐ Arsenic ☐ Pesticides ☐ Aluminum

Chemical Name, Date, Length of exposure: _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you have any pets or animals? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures?

☐ No ☐ Past ☐ Current

Do you or have you ever lived or worked close to a power plant, busy highway, paper mill, steel factory, etc.?

☐ No ☐ Past ☐ Current If yes, please specify: _____ For how long? _____

What brands of personal care products do you use? (Deodorant, lotions, soaps, make-up, etc.)

_____

Please list anything else you would like us to know that was not otherwise covered:

Thank you for taking the time to fill out this questionnaire! We look forward to working with you.

~The Sycamore Chiropractic and Nutrition Team