

This information is required for your case history file

TODAY'S DATE _____

Name: _____ Birth date: _____ Age: _____ Social Security #: _____

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

Telephone: _____ Sex: _____ Height: _____ Weight: _____ Marital Status: M S W D # of Children: _____

Occupation: _____ Employer: _____ Years Employed: _____

Employer's Address: _____ Work Number: _____

Spouse's Name: _____ Occupation: _____ Employer: _____

Person Responsible for this Account: _____ Referred By: _____

Were you involved in an automobile or work related accident? Yes No

What is the reason you are coming to the office at the present time? _____

Name of Primary Care Physician: _____

SYMPTOMS

- Headache
- Entire Head
- Back of Head
- Forehead
- Temples
- Migraine
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Light bothers eyes
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears
- Double vision
- Vertigo
- Staggering
- Difficulty swallowing
- Excess yawning

NECK

- Pain in neck
- Neck pain with movement
- Pinched nerve in neck
- Neck feels out of place
- Stiff neck
- Muscle spasm in neck
- Grinding sounds in neck
- Grating sounds in neck
- Popping sounds in neck
- Arthritis in neck

HABITS

Alcohol (#/week) _____ Water (Glasses/day) _____
Sleep (Hrs/night) _____ Exercise (X/week) _____
Appetite (meals/day) _____ Tobacco (packs/day) _____

ALLERGIES _____

SHOULDERS

- Pain in should joint
- Pain across shoulders
- Bursitis R-L
- Arthritis R-L
- Can't raise arm
 - above shoulder level
 - over head
- Tension in shoulders
- Pinched nerve - shoulder R-L
- Muscle spasms in shoulder

CARDIO/RESPIRATORY

- Chest pain
- Shortness of breath
- Pain around ribs
- Pain over heart
- High blood pressure
- Low blood pressure
- Swelling in ankles
- Chronic cough
- Spitting up blood
- Wheezing

ARMS & HANDS

- Pain in upper arm R-L
- Pain in forearm R-L
- Pain in hands R-L
- Pain in fingers R-L
- Pinched nerve in fingers R-L
- Sensation of pins & needles in fingers R-L
- Fingers go to sleep R-L
- Hands cold R-L
- Swollen joints in fingers R-L
- Sore joints in fingers R-L
- Arthritis in fingers R-L
- Loss of grip strength

MID-BACK

- Mid- Back pain
 - Pain btw. shoulder blades
 - Sharp stabbing pain
 - Muscle Spasm
- CHEST**
- Chest pain
 - Shortness of breathe
 - Pain around ribs
 - High blood pressure
 - Low blood pressure

ABDOMEN

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Vomiting
- Vomiting of blood

GENITO-URINARY

- Bed wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney stones or infection
- Night voiding
- Painful urination
- Prostate trouble

WOMEN ONLY

- Menstrual pain
- Cramping
- Irregularity
- Hot flashes
- Lumps in breast

LOW BACK

- Low back pain
- Low pack pain is worse:
 - working
 - lifting
 - stooping
 - standing
 - sitting
 - bending
 - coughing
- Pinched nerve in low back
- Low back feels out of place
- Muscle spasm
- Arthritis

HIPS, LEGS, & FEET

- Pain in buttock R-L
- Pain in hip joint R-L
- Pain down leg R-L
- Pain down both legs
- Leg cramps
- Pins/ needles in legs R-L
- Numbness of legs R-L
- Numbness of feet R-L
- Numbness of toes
- Cramps in feet R-L
- Swollen ankles R-L
- Swollen feet R-L
- Painful joints in toes
- Varicose veins

GENERAL

- Nervousness
- Irritable
- Depressed
- Fatigue
- Fainting
- Twitching
- Numbness
- Sweats
- Tension
- Nosebleeds

Voiding (X/day) _____

Bowel (#/day) _____

Have you ever been treated for this problem? Yes No

If yes, by: Physician Doctor of Chiropractic Physical Therapist Osteopath Other

What did they do and/or recommend? _____

When did your symptoms appear? _____ Is this condition getting progressively worse? _____

CONDITIONS – Check any conditions you have now or have had in the past:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Allergy shots | <input type="checkbox"/> Fractures | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tumor/ Growths |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Surgeries : |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prosthesis | _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt | _____ |

MEDICATIONS (List your current medications) _____

VITAMINS/HERBS/MINERALS _____

PAIN DIAGRAM

Please use the following symbols and indicate where you pain is on the diagram below.

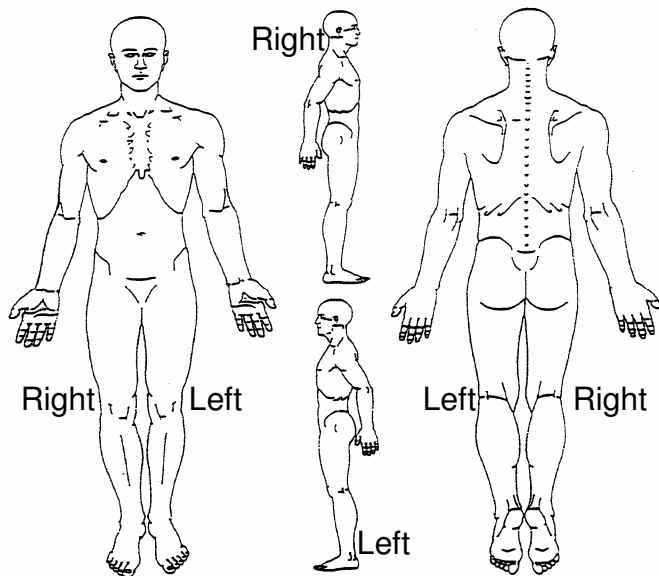
Aching
▲▲▲

Numbness

Pins & Needles
●●●

Burning
X X X

Stabbing
/ / /



Please circle the number below that represents your level of pain today.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Patient Signature

Date



Clifton Springs Hospital & Clinic
 2 Coulter Road
 Clifton Springs, NY 14432

Consent to Chiropractic Treatment/Procedure

Name: _____ Date of Birth: _____

1. I hereby authorize Dr. Michael J. O'Connor at The Springs Integrative Medicine Center and Spa at Clifton Springs Hospital and Clinic to perform the following chiropractic procedure upon me/the named patient.

Adjustment is a specific application of forces to correct and/or reduce vertebral subluxation. Vertebral subluxation occurs when one or more of the vertebra in the spinal column become misaligned or do not move properly. Adjustments to correct subluxation are done either by hand or with an instrument.

Soft tissue manipulation treats the muscles, tissues and lymphatic (drainage) systems in a specific area, in order to reduce pain and dysfunction.

2. My chiropractor has fully explained to me the purpose of the procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, both during the procedure and the recuperation period, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of the alternatives to the proposed treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
3. The risks discussed include, but are not limited to: bruising, soreness or aching, which may last a few days or longer.
4. I certify that I am not currently pregnant. I am aware that some chiropractic procedures can not be performed during pregnancy.
5. I understand that during the course of the procedure(s), conditions may arise that require additional medical care with another health care provider. I am aware that my chiropractor will inform me if he/she believes that I need to seek medical care. I am further aware that any additional non-chiropractic care and treatment I require will be at my own cost and expense.
6. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the proposed treatment/procedure.
7. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above that do not pertain to me.

 Signature Patient/Relative/Guardian*

 Print Name

 Date/Time

 Relationship to Patient

 Interpreter (if required)

 Print Name

 Date/Time

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks) the proposed treatment/procedure. I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

 Chiropractor's Signature

MICHAEL J. O'CONNOR, DC, DABCO
 Print Name

 Date/Time

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.



Clifton Springs Hospital & Clinic
 2 Coulter Road
 Clifton Springs, NY 14432

Michael J. O'Connor, DC, DABCO

Patient Financial Responsibility Agreement for Non-Covered Services

The provider who signed this form below has explained to me, the patient, that my health Plan has determined that the health services described below are **not covered** under my health benefit plan for **the following reason** (note checked box):

- The health service is not a covered benefit under my health benefit plan.
- I did not contact my health care professional to obtain the required referral for my visit to this provider. The provider informed me that failure to do so would mean that the care and services I receive will not be covered.
- I am subject to a waiting period for a pre-existing condition, and I have not completed the required waiting period for the treatment of this pre-existing condition.
- I have exhausted my allotment of this benefit.
- Although this provider participates with my Health Plan, the services I have requested are not within the scope of this provider's participation agreement with the Health Plan.

I have directed the provider whose signature appears below to render the health services requested. I understand that:

- **The Health Plan will not pay the charges for these services, in whole or in part.**
- **The provider will not submit a claim to the Health Plan.***

I hereby agree to pay this provider in full for the cost of the health services described below. The provider disclosed this information to me and I signed this agreement **before** the provider supplied the specified health services to me.

If I am an HMO member, my signature does not imply, nor shall it be interpreted as being, a waiver by me of my rights to grieve and appeal under Public Health Law (PHL) Article 44, or to appeal an initial or final adverse determination under PHL Article 49 or Insurance Law Article 49. If I am an enrollee under an employer-sponsored self-insured plan, I do not waive my grievance and appeal rights under that health plan.

Patient Name (please print) _____

Patient Signature _____ Date _____

Provider Name (please print) _____

Provider Signature _____

Description of Service:

_____	Cost for Service \$	_____
_____	Cost for Service \$	_____
_____	Cost for Service \$	_____
Total Cost for Service \$		_____

*Provider may submit a claim to the Health Plan when the patient's secondary carrier requires a denial.



Clifton Springs Hospital & Clinic
2 Coulter Road
Clifton Springs, NY 14432

**ACKNOWLEDGEMENT OF
RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I received a copy of Clifton Springs Hospital & Clinic's Notice of Privacy Practices.

Date

Signature of Patient or Patient Representative

Printed Name

Witness

**DOCUMENTATION OF
THE ATTEMPT TO OBTAIN WRITTEN
ACKNOWLEDGEMENT OF THE DELIVERY OF
THE NOTICE OF PRIVACY PRACTICES**

I delivered the Clifton Springs Hospital & Clinic's Notice of Privacy Practices to

_____ on _____. I attempted to obtain an
acknowledgement of

the receipt of Clifton Springs Hospital & Clinic's Notice of Privacy Practices but was unable to do
so

because _____

Date

Signature of Employee

Printed Name