Cumberland Chiropractic Ltd.

Name:_____ **SS#:**_____ **Age:**_____

Address:_____**City:**_____**ST:**_____ **Zip:**_____

Phone(H/C):_____ **(W):**_____ **Birth Date:**_____

Race: (American Indian) (Asian)(White)(Alaska Native) (African American) (Other_____)

Ethnicity: (Not Hispanic or Latino) (Hispanic or Latino)

Employer:_____ **Spouse's Name:**_____

Email:_____**Referred By:(Friend) (Relative) (Website)(Other_____)**
Occupation:_____ **Do you work with solvents? (Yes) (No)**
Which one of our patient's should we thank you for referring you?:_____

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset) (Other___)
Date of Accident:_____ **Did you report it:** (Yes) (No)
Previous Chiropractic:_____ **Previous Doctor:**_____

X-ray Release: *I understand that these X-rays are property of Cumberland Chiropractic and that if I request to borrow my X-rays in order to take them out of the office, I will be charged a deposit of $30 that will be help by Cumberland Chiropractic until such time I return my x-rays of thirty days has passed at which time I forfeit the deposit.*

Pregnancy Release: *This is to certify that to the best of my knowledge, I am not pregnant and that Cumberland Chiropractic has my permissions to take X-rays.*

Signature:_____**Date:**_____

Office Policies: *If I am accepted as a patient of Cumberland Chiropractic, I agree to pay for all services, including services not covered by my insurance company. If I suspend/terminate my treatment without talking with the doctor, it will be understood that I have reached maximum healing for my treatment. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that nay amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend of terminate, any fees for professional services rendered me will be immediately due and payable. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. It is understood and agreed the amount paid the Doctor for x-rays, is for the examination only and the x-rays negatives will remain the property of this office.

Signature:_____**Date:**_____
Patient/Guardian:_____**Date:**_____

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Do you have:

Pacemaker____	Diabetes_____	Hypertension__	Stroke _____
Heart Attack/Angina___	Epilepsy_____	Corrective Lenses_____	Allergies_____
Phlebitis_____	Hearing Aids___	Polio (when)___	Glaucoma_____
Hearing Loss___	Cataracts_____	Lower Back Pain_____	Blurred Vision__
Ringing in the ears_____	Mid Back Pain__		Headaches____
Upper Back/Neck Pain__			

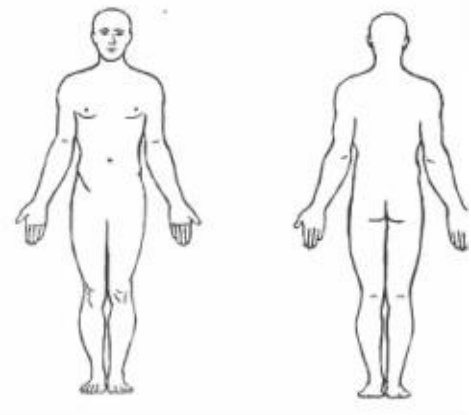
Have you had any recent weight loss or unexpected fever or fatigue? (Yes) (No)

Stiffness In:	Numbness In:	Tingling In:	Weakness In:
Neck___	Arm__R__L	Arm__R__L	Arm__R__L
Mid Back_____	Hand__R__L	Hand__R__L	Hand__R__L
Lower Back____	Fingers__R__L	Fingers__R__L	Fingers__R__L
Arms R L	Legs__R__L	Legs__R__L	Legs__R__L
Legs R L	Feet__R__L	Feet__R__L	Feet__R__L

Please list the main area(s) of you pain:_____

Does it travel to another area?_____Where is it located?_____

Please Circle Any Activities Which Aggravate Your Condition: (Standing) (Walking) (Sitting) (Lying) (Bending) (Lifting) (Twisting) (Coughing) (Other_____)



Pain Chart:

Please Label the Area(s) of Today's Pain

_____

_____

_____

_____

_____

_____

Have you had any pain in this area in the past?_____

Describe any previous falls, slips, trips, or motor vehicle accidents in the last 5 years?_____

_____

When did you first experience pain?_____ **How long have you felt pain?**_____

How often do you experience pain? (constantly) (daily) (once a week) (once of month) (occasionally)

Does the pain radiate to the arms or legs?_ If so, is the pain greater in the arms/legs/spine?___Is the pain (increasing) (decreasing) (not changing)?

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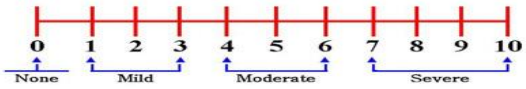

Please circle the number on the scale, where your pain is today?

Past Medical History

Surgery: What kind?_____ **Date of Surgery:**_____
What kind?_____ **Date of Surgery:**_____
What kind?_____ **Date of Surgery:**_____
What kind?_____ **Date of Surgery:**_____

Allergies? _____

What medications you are currently taking?

1.) _____ 2.)_____ 3.)_____
4.) _____ 5.)_____ 6.)_____

Allergies to Medications?_____

Medication:_____
Route: (Oral) (Intravenous)(Other)
Frequency:_____
Began Use:_____
Discontinued Use:_____

Medication:_____
Route: (Oral) (Intravenous)(Other)
Frequency:_____
Began Use:_____
Discontinued Use:_____

Smoking Status: Current Every Day Smoker
Current Some Day Smoker
Former Smoker
Never Smoker

Smoking Start Date:_____
End Date:_____

In an effort to quit smoking, I am currently taking:_____

Does your family history include (heart disease)(hypertension)(cancer)(diabetes)(arthritis) Other_____
Eyes: Have you had loss of vision or double vision? (Yes) (No) **Do you drink alcohol?** (Yes) (No)
Ears/Nose/Throat: Do you have hearing or speech problems? (Yes) (No)
Heart: Do you have dizzy spells, irregular heartbeat, or palpitation? (Yes) (No)
Respiration: Do you have persistent cough, shortness of breath of wheeze? (Yes) (No) **Have you ever coughed blood?** (Yes) (No)
Gastro: Have you even vomited blood? (Yes) (No) **Do you have abdominal/stomach pain?** (Yes) (No)
Any nausea, vomiting, or constipation? (Yes) (No)
GU: Discomfort in urinating? (Yes) (No) **Get up at night to urinate?** (Yes) (No)

For Doctor's Use ONLY:_____

Cumberland Chiropractic Ltd.

Please circle the number which most closely describes your condition right now:

1. Pain Intensity

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worse Possible Pain

2. Frequency of Pain

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

No Pain | Occasional Pain 25% of the day | Intermittent Pain 50% of the day | Frequent Pain 75% of the day | Constant Pain 100% of the day

3. Personal Care (Washing, Dressing, etc.)

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

No Pain | Mild Pain No Restrictions | Moderate Pain Need to go slowly | Moderate Pain Needs some assistance | Severe Pain 100% assistance

4. Travel (Driving, Riding, etc.)

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

No Pain On long trips | Mild Pain On Long Trips | Moderate Pain On Long Trips | Moderate Pain On Short Trips | Severe Pain On Short Trips

5. Work

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

Can Do Usual Work Plus extra work | Can do usual work No Extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot Work

6. Recreation

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

Can do all activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities

7. Sleeping

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

Perfect Sleep | Mildly Disturbed | Moderately Disturbed | Greatly Disturbed | Totally Disturbed

8. Lifting

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

No Pain With heavy weight | Increased Pain With heavy weight | Increased Pain With moderate weight | Increased Pain With light weight | Increased Pain With all weight

9. Walking

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

No pain Any distance | Increased pain after 1 mile | Increased pain after half mile | Increased pain after quarter mile | Increased pain with all walking

10. Standing

----------(0) ---------- (1) ---------- (2) ---------- (3) ---------- (4)

No pain After several hours | Increased pain after several hours | Increased pain after one hour | Increased pain after half hour | Increased pain with any standing

Patient's Signature:_____ Date:_____

Cumberland Chiropractic Ltd.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Some examples of how we may use or disclose your healthcare information:

- Your health care provider or a staff member may disclose your health information to another healthcare provider, hospital, or treatment facility in order to refer you for diagnosis, assessment, treatment, or testing.
- Your health care provider or a staff member may disclose your health information, including your billing records, to another party such as an insurance carrier, an HMO, a PPO, or your employer or their insurance carrier, if they are potentially responsible for the payment of the services your receive.
- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders, information about your treatment alternatives, or other health related information that may be of interest to you. If you refuse us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
- At any time, you may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. You are also entitled to an electronic copy of any records maintained in that format.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under Federal law, we are permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- We are permitted to use or disclose your health information when required to do so by applicable federal or state laws.
- We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information to under state or federal law.
- We are permitted to use or disclose your health information to an appropriate governmental authority if we reasonably believe you are the victim of abuse, neglect, or domestic violence.
- We are permitted to use or disclose your health information for state and federal health oversight activities of the healthcare system and government benefit programs.
- We are permitted to use or disclose your health information to a law enforcement authority as required by laws to report certain types wounds or physical injuries or to comply with a court order, subpoena, or administrative request authorized by law.
- We are permitted to use or disclose your health information to a law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- We are permitted to use or disclose your health information to a correctional institution if we provide healthcare services to you as in inmate.
- We are permitted to use or disclose your health information if we provide healthcare services to you in an emergency.
- We are permitted to use or disclose your health information if we provide care to you that is related to a workplace injury to the extent necessary to comply with Worker's Compensation rules and regulations.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. Your revocation request will not be honored if:

- We have already released your health information before we receive your request to revoke your authorization.
- You were required to give your authorization as a condition of obtaining insurance; the insurance company may have a right to your health information if they decide to contest any of your claims.
- Any circumstance in which we are permitted or required to use or disclose your health information without your consent or authorization.

Your Right to Limit Use or Disclosure

If there are healthcare providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want use to disclose your health information, please let us know in writing which providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your healthcare information. We are not required to agree to your restriction; however, if we agree with your restriction, the restriction is binding on us. If we do not agree to your restriction, you may seek care from another healthcare provider.

Other than the circumstances described above, any other use or disclosure of your health information will only be made with your written authorization.

Patient Signature:_____ Date: _____