Welcome to Breakfast Hill Chiropractic, PLLC!

Today's Date: / /		
Name:		
Home Phone:	Work Phone:	
Cell Phone:	Cell Phone Carrier:	
Email:	Appt. Reminders: Email Text Both	
Street Address:		
City:	State:	Zip Code:
Birth Date: / /	Social Security #:	
How did you learn about our office?		
Previous Chiropractic care? Yes No		
Date of last Chiropractic visit: / /		
Marital Status:	Spouse's Name:	
Names and ages of children:		
Hobbies:		
Have you "liked" Breakfast Hill Chiropractic on Facebook yet? Yes No		
Employer/Business:		
Occupation:		
Is this a work-related injury? Yes No		
Auto accident? Yes No		

I hereby authorize the Doctor of Chiropractic to provide and all forms of evaluation, x-rays, and care that may be indicated in connection with the patient above, and further authorize and consent that the Doctor of Chiropractic chooses and employs such assistance as he or she feels fit. I also understand that prior to care, full explanation of the procedure(s) involved will be given. I agree to pay all services rendered in this office.

Signature: _____ **Date:** _____

Relationship to Patient: _____

This is a Confidential Health Report

Name:
Date of Birth:
Date:
Why are you pursuing Chiropractic care?

In order for us to better understand your current level of health, please circle any of the following body signals that you or a family member currently or have had.

Dizziness or Fainting	Self	Family	High Blood Pressure	Self	Family
Headaches	Self	Family	Bladder Problems	Self	Family
Arthritis	Self	Family	Kidney Problems	Self	Family
Postural Imbalance	Self	Family	PMS	Self	Family
Short Leg/Orthotics	Self	Family	Menopausal Symptoms	Self	Family
Intestinal Problems	Self	Family	AIDS	Self	Family
Frequent Colds	Self	Family	Cancer	Self	Family
Ear Infections	Self	Family	Epilepsy	Self	Family
Sinus Problems	Self	Family	Heart Disease	Self	Family
Multiple Sclerosis	Self	Family	Ulcers	Self	Family
Alcoholism	Self	Family	Diabetes	Self	Family
Lung Disease	Self	Family	Stroke	Self	Family
Scoliosis	Self	Family	Hyper/Hypothyroidism	Self	Family

Please list all prescriptions or over-the-counter drugs now taking: _____

_____

_____

Allergies: _____

Stress Test

The following areas of stress can cause misaligned spinal vertebrae (Subluxation.) Which do you recognize of these stressors?

Please check any that may apply now or at any time in your life

Birth Trauma		Hidden Feelings		Children Stress	
Slips and Falls		Extensive Computer Work		Sleeping Position - stomach	
Car Accidents		Quick Temper		Carrying heavy purse/bag/child	
Sports Injuries		Repetitive Lifting/Bending		Smoker/Second-hand smoke	
Physical Abuse		Driving too many hours		Poor Diet / Excessive Sugar	
Work Injuries		Prescription Drugs		Caffeine	
Poor Posture		Relationship Stress		Artificial Sweetener	
Career Stress		Sitting on wallet for years		Continuous Sitting/Standing	

Signature: _____ Date:_____

BREAKFAST HILL
CHIROPRACTIC, P.L.L.C.

Insurance Subscriber Authorization Form

I _____ verify that I am the current and legal subscriber for this Insurance Policy. (Circle One)

YES **NO**

If **NO** please fill out below subscriber information:

Subscriber Name: _____

Subscriber Address (If different from Patient):

_____

_____

_____

Subscriber Date of Birth (mm/dd/yyyy): _____

*Name:*_____ *Date:*_____

*Signature:*_____

Terms of 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: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of spinal nerve interference. Our chiropractic method of correction 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: Also known as spinal nerve interference. 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.

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

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

I, _____have read and fully understand the above statements.

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. Date of last menstrual period:

_____

_____ _____

(signature) (date)

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Breakfast Hill Chiropractic uses health information about you for treatment, to obtain payment for treatment with authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Breakfast Hill Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Breakfast Hill Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Breakfast Hill Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy officer Dr. Jeffrey Rogers and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Breakfast Hill Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms and of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Dr. Jeffrey Rogers at (603)-964-1500.

_____ _____

Patient Signature Date

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

___ACTIVITIES:			EFFECT:	
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

Patient signature: _____ **Today's Date:** __/__/__

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

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 pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

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1 – What is your pain RIGHT NOW?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

2 – What is your TYPICAL or AVERAGE pain?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

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

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.