

# CHIROPRACTIC HEALTH HISTORY

## PATIENT INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_  
                    First                    Middle                    Last

Address \_\_\_\_\_  
                    Street                    apt                    City                    State                    Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ email \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: male female Marital Status: \_\_\_\_\_

## EMPLOYMENT INFORMATION

Occupation: \_\_\_\_\_ Years: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
                    Street                    apt                    City                    State                    Zip

Who may we thank for referring you to our office? \_\_\_\_\_

(MINORS ONLY) List guardian names, addresses and contact information.

\_\_\_\_\_  
Name                                    Street                                    State                    Zip                    Phone

IN CASE OF EMERGENCY CONTACT: \_\_\_\_\_

\_\_\_\_\_  
                                    Name                                    Relationship                    Phone  
\_\_\_\_\_  
                    Street                    apt.                    City                    State                    Zip

## PATIENT CONDITION

Reason for visit \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

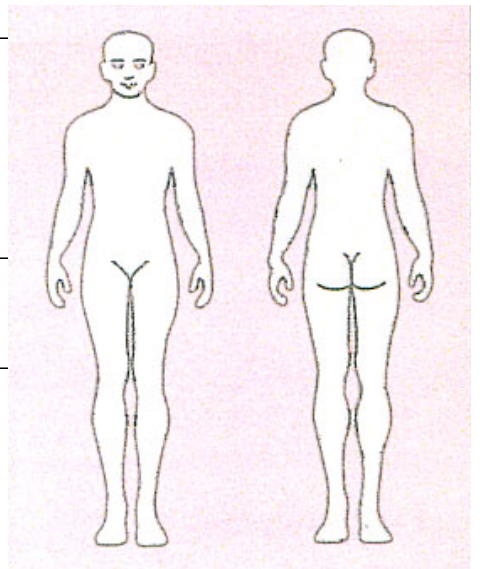
Mark an **X** on the picture where you continue to have pain, numbness or tingling

Rate the severity of pain on a scale of 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Circle the following terms that describe your symptoms: Sharp Dull Achy  
Throbbing Shooting Numb Stiff Tingling Burning Other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Activities or motions which are difficult to perform: Sitting Standing Walking  
Running Bending Lifting Lying Down Sleep Other \_\_\_\_\_



**HEALTH HISTORY**

**What treatments have you already received for your condition?**

Medications Surgery Physical Therapy Chiropractic Acupuncture Massage None Other \_\_\_\_\_

**List the names and locations of other doctors or health care providers who have treated you for this condition:**

\_\_\_\_\_  
Name Street City State Zip Phone

\_\_\_\_\_  
Name Street City State Zip Phone

**Please list any diagnosis you have received for this condition and by whom?** \_\_\_\_\_

**List any imaging or special studies you have had for this condition** \_\_\_\_\_

	Type(s) of study	date(s)	
<b>Circle if you currently have or have had in the past any of the following:</b>			
AIDS/HIV	Diabetes	Liver Disease	Psychiatric Care
Alcoholism	Emphysema	Measles	Rheumatoid Arthritis
Allergy shots	Epilepsy	Migraine Headache	Rheumatic Fever
Anemia	Fractures	Miscarriage	Scarlet Fever
Anorexia	Glaucoma	Mononucleosis	Stroke
Appendicitis	Goiter	Multiple Sclerosis	Thyroid Problems
Arthritis	Gonorrhea	Mumps	Tonsillitis
Asthma	Gout	Osteoporosis	Tuberculosis
Bleeding Disorders	Heart Disease	Pacemaker	Tumors, Growths
Breast Lump	Hepatitis	Parkinson's Disease	Typhoid Fever
Bronchitis	Hernia	Pinched Nerve	Ulcers
Bulimia	Herniated Disk	Pneumonia	Vaginal Infections
Cancer	Herpes	Polio	Venereal Disease
Cataracts	High Cholesterol	Prostate Problem	Whooping Cough
Chicken Pox	Kidney Disease	Prosthesis	Other _____

**Exercise:** None Moderate Daily Heavy **Work Activity:** Sitting Standing Light labor Heavy labor

**Are you pregnant?** Yes No **If "yes" what is your due date?** \_\_\_\_\_

**List any injuries or surgeries you have had in the past:**

\_\_\_\_\_  
Description Date

\_\_\_\_\_  
Description Date

## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays, and physiotherapy treatments, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as backup for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose, and risks of chiropractic adjustments, and other recommended procedures. I have had all my questions answered to my satisfaction and I do understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment. I have, myself, decided it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment.

**Name and Address of Clinic**

Vose Chiropractic  
551 Boylston St. 4<sup>th</sup> floor  
Boston, MA 02116

**Name of Doctor Treating this Patient**

Dr. Erik Vose, D.C.

\_\_\_\_\_  
Print name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient's Representative (if  
minor or physically incapacitated)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to Patient's Signature

\_\_\_\_\_  
Date

## Financial and Billing Policies

I would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial and billing policies of our office, I would like to explain how your medical bills will be handled.

**Declaration:** You are the primary person responsible for your bill. Charges for the treatment are due at the time of service, unless other payment arrangements are made.

**Payment Methods:** Payments may be made using cash, check, Visa or Mastercard. A receipt will be furnished for you upon request. If you wish to submit claims to your insurance company, a detailed description of your visit will be made available to you within one week from your visit.

**Returned Checks:** If your check is returned by the bank due to insufficient funds, there will be an additional \$25.00 charge added to your account which you are responsible to pay.

**Cancellation Policy:** We request a 24-hour notice on any cancellation of appointments in order to smoothly deliver service to all our patients. We understand that there may be rare exceptions, but it is mandatory to cancel appointments at your earliest convenience. If you fail to keep an appointment without cancellation, you will be charged for your visit in full. If you fail to keep three or more appointments, we reserve the right to ask you to seek medical care elsewhere.

Thank you for taking the time to read the policies of this office. I sincerely appreciate your patronage.

Dr. Erik Vose

I have had the opportunity to read and discuss all of the above information, and I fully understand all of its meaning and its terms. I am aware of and accept these policies noted above.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## OMBE Privacy Policies Notice

This notice describes how your medical information may be used and disclosed, how you can access this information, and how your privacy is being protected at OMBE. OMBE, all health care providers at OMBE, and all associates providing service at OMBE are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. The privacy of your medical records is important to us and we are committed to protecting your medical records. We create a record of the services you receive at OMBE in a paper chart and on a computer. We need this record to provide you with quality care and to comply with certain legal requirements. In order to maintain the service level that you expect from a health care office, we may need to share limited personal medical and financial information. Your medical records are the property of this health care office, but the information in the medical record belongs to you. This notice also describes your rights and certain duties we have regarding the use and disclosure of medical information.

### ***How OMBE May Use or Disclose Your Health Information***

**Treatment:** We use medical information about you to provide your health care. We may disclose your health care information to other health care providers within our practice for the purpose of treatment, payment or health care operations. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with OMBE. We may share your medical information with other physicians or other health care providers who will provide services that we do not provide. We may share this information with a physician who will need to treat you, or a laboratory that performs a test.

**Payment:** We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. For example, we may disclose your health information to your insurance provider or a third party for the purpose of payment, to receive prior approval, or to determine whether your plan will cover the treatment.

**Workers' Compensation:** We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**Health Care Operations:** We may use and disclose medical information about you to operate this health care practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence, and qualifications of our staff. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud detection and compliance programs. We may also share your medical information with our "business associates", such as our appointment scheduling and billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. Additionally, the health care practice has an open waiting room where patients may be seen by other patients. The secure area around the front desk also has a computer and fax machine that may be visible to the public. This area is limited to OMBE staff and health care providers only and the computer has an automatic screen saver that is activated after two minutes without activity.

**Appointment Reminders:** We may contact you for appointment reminders. If you are not available, we may leave a message via email, a voicemail inbox, answering machine, or with the person answering your home phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

**Notification and Communication with Family:** We may disclose your health information to notify a family member or another person responsible for your care about your location and general condition in the event you are sick or injured. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures. We may disclose this information in an emergency situation.

**Marketing:** We may contact you to give you information about products or services, case management, care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We do not disclose your personal contact information including your phone number or email address to any third party for marketing or solicitation.

**Required by Law:** When the law requires us to report abuse, neglect, domestic violence, we will comply with the relevant legal requirements. We may, and are sometimes required by local, state, or federal law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may disclose your

Erik S. Vose D.C.

OMBE Integrative Health Center 551 Boylston St. Boston, MA 02116 617.447.2222 [www.ombecenter.com](http://www.ombecenter.com)

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health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Public Health & Safety:** We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child, elder, or dependent adult abuse or neglect; and reporting domestic violence. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Special Government Functions:** If you are a member of the armed forces, we may release protected health information about you if it relates to military and veteran activities. We may also release your protected health information for national security purposes, protective services for the President, and medical suitability or determinations of the Department of State.

**Deceased Persons:** We may disclose your health information to coroners, medical examiners, funeral directors, or organizations involved in procuring, banking, or transplanting tissues.

**Change of Ownership:** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

**Right to Request Special Privacy Protections:** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit in our use or disclosure. We reserve the right to accept or reject your request, and will notify you of our decision.

**Right to Request Confidential Communications:** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable communication requests submitted in writing.

**Right to Inspect and Copy:** You have the right to inspect and copy your health information. To access your health information, submit a written request detailing the information you want access, inspect, or copy. We will charge a reasonable fee, as allowed by federal law. We may deny your request under limited circumstances. You have the right to appeal our decision if we deny access your child's records in the case that access could cause harm to your child.

**Right to Amend or Supplement:** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about OMBE's denial and how you can disagree with the denial within thirty (30) days of receipt of your written request. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

**Right to an Accounting of Disclosures:** You have a right to receive an accounting of disclosures of your health information made by this office, except that this office does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the Treatment, Payment, Health Care Operations, Notification and Communication with Family paragraphs. Additionally, this office does not have to account for disclosures otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this office has received notice from that agency or official that providing this accounting would be likely to impede their activities.

### ***More About OMBE's Privacy Policy***

We reserve the right to amend this Privacy Policies Notice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice will apply to all protected health information that we maintain. You have the right to request a current copy of this Notice which is maintained on our website and at the front desk. If you would like a more detailed explanation of these rights, to exercise one or more of these rights, or submit any complaints in regards to this Notice, please contact our Privacy Officer, Jessica Molleur. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint without the risk of penalization to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.

Erik S. Vose D.C.

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## OMBE Privacy Policies Acknowledgement

I have received, read, and understood OMBE's Privacy Policies Notice. I understand how this health care office and its health care providers may use or disclose my health information. I understand when this health care office may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Privacy Policies Notice. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of this health care office.

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Signature of Patient or Authorizes Representative

Date