Miniaci Chiropractic & Acupuncture Center, LLC
53 High St.
East Haven, CT 06512
203-469-5210

Initial Questionnaire

Name:_____ Chart#:_____ Date:_____

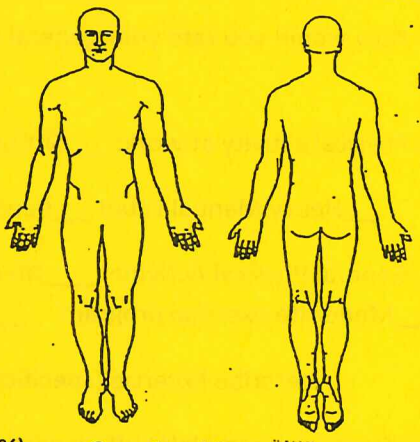
Person to Notify in case of Emergency: Name:_____Phone #:_____ Relation:_____

1. Please Describe Your Complaint(s); if more than one please number them according to severity:

_____

_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOM



a. Description (What does your pain feel like?)

___SHARP ___SHOOTING ___STIFF

___DULL ___GRIPPING ___NUMBNESS

___ ACHE ___BURNING ___PINS & NEEDLES

___ WEAK ___TINGLING ___THROBBING

___PULSATING ___RADIATING ___Pressure

___STABBING ___ OTHER ___Sore

b. Frequency (How often does your pain occur) ***Check one*** :

__Constant (76-100%) __Frequent (51-75%) __ Intermittent (26-50%) __Occasional (25% or less)

c. Intensity: Circle the # that best describes your overall level of discomfort

NO PAIN (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) UNBEARABLE PAIN

2. a. How long has your problem been present?__ days __weeks __ years. Has it __decreased __not change__ increased?

b. If it followed a specific incident (motor vehicle accident, work injury, sport, slip &fall), please date & describe:

_____

_____

c. If from lifting, how many lbs? ___ In what position were you? ___Bent forward ___ Bent Backwards__ Knees bent__Twisted

Did you lift__once ___a few times ___many times? Do you repeat the same motion often? ___ YES ___NO

3 What doctors/providers have seen for this episode? ___ DC __MD __DO __PT

Currently seeing? ___ DC__MD__DO__PT Results: _____

a. Examinations included: ___ X-rays___/___/___ Where_____ ___CT Scan ___/___/___ Where_____

___MRI___/___/___ Where_____ ___ Other ___/___/___ Where _____

b. Treatment has included: ___ Exercise ___Heat ___Cold ___Medications ___Support ___Electrical Therapy

___Manipulation ___Surgery. Comments:_____

4. In the past have you been treated for the same or similar problem? __Yes __No IF yes , when?_____
Type of provider seen: __ DC __MD__DO __PT

5. What makes your problem better ?___Lying down__Walking ___ Standing __Sitting ___ Movement/ Exercise
___Inactivity___ Heat/Ice ___Chiropractic _____Medication, type_____

6. What makes your problem worse? __ Lying down __Walking ___Standing ___Sitting ___Movement/ Exercise
___Inactivity ___Heat/Ice ___Twisting/Turning ___Lifting ___Laundry ___Making the bed ___Groceries
___Pet Care ___Cooking ___ Going Up/Down Stairs __Housework ___ Phone/Computer usage ___Job Tasks
___Driving ___ Caring for Family ___ Vacuuming ___Getting in/out of Car

7. How would you rate your general stress level? ___Little or No Stress ___ Minimal Stress
___ Moderate Stress ___ Greatly Stressed

8. Physical activity at work: ___ Sitting more than 50% of workday ___ Light physical work ___ Manual Labor
___Heavy Manual Labor ___Repeated Motion, describe (specific)_____

9. General Physical Activity: ____No regular exercise program ___ Light exercise program
___Moderate exercise program ___Strenuous exercise program

Describe Excerise (specific)_____

10. Does your complaint affect your ability to work or otherwise be active? (check any that apply).

____No effect _____Need limited assistance with common everyday tasks.

___ Cannot perform work duties as of ___/___/____ (date)

____Need assistance often ___/___/____ Unable to function without assistance___/___/____

_____ _____

Patient Signature Date Completed

_____

OFFICE USE ONLY

Notes:_____

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Name_____ Date_____

Address:_____

Home Phone:_____ Cell Phone/Pager_____

Date of Birth:_____ Social Security #_____

Marital Status: S M D W Spouse Name:_____

Spouse DOB:_____ Spouse Social Security #_____

Email address: _____

Employer Name & Address:_____

Work #_____ Extension_____

Person to notify in an emergency (name/phone #/ relation to you:_____

Since the last time we saw you, have you had any of the following:

Fractures/dislocations [] No []Yes
If yes, where:_____when:_____
_____when:_____

Surgery []No []Yes
If yes, what surgery:_____when:_____
_____when:_____

Serious Illness []No []Yes
If yes, what illness:_____when:_____

Still under doctor's care? [] Yes []No Dr:_____

Bleeding Disorder or Serious Infection []No []Yes
Date:_____ Dr._____ still under care? []No []Yes

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PATIENT INFORMATION CONSENT TO DISCLOSURE

I, _____, a patient of Miniaci Chiropractic & Acupuncture LLC, do hereby attest that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

If there are any parties/businesses with whom my personal health information should not be disclosed, or if there are any restrictions I want placed on my information disclosure it is my responsibility to notify Miniaci Chiropractic & Acupuncture LLC in writing. (A form for this purpose is available from the chiropractic office upon request)

Signed: _____- Dated: _____-

Witnessed: _____- Dated: _____-

This form is part of a HIPAA compliance program.

Patient Information Consent to Disclosure.doc

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Patient Pregnancy Disclaimer

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In doing so I release the doctor and clinic from potential damage arising from this procedure.

At the present time:

___ I am sure that I am not pregnant.

___ It is possible that I could be pregnant.

___ I am pregnant.

Date of LMP (Last Monthly Period): ___/___/___

Signature-Patient:_____ Dated:_____

Signature-Witness:_____ Dated:_____

Preg Disclaimer.doc 2012

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I _____ of _____ (town)
Do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissues. Physical therapy modalities and exercises may also be used. Although spinal manipulation is considered to be a safe and effective form of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with manipulation and therapy procedures as follows:

Chiropractic care is the science, philosophy and art of locating and correcting spinal subluxations (misalignments) and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this office. As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgement and expertise in working with like cases. It is not reasonable to expect my chiropractor to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. An undesirable result, or side effect, does not necessarily indicate error in judgment or an improper treatment.

I understand that the chiropractor will use his/her hands or a mechanical device upon my body to a joint which may cause an audible "pop" or "click". As with any health care procedure there are certain complications which may arise during a chiropractic adjustment. Those complications include sprains/stains, soreness, dizziness, nausea, dislocations, fractures, disc injuries, or cerebral-vascular accidents (stroke). These complications are extremely rare occurrences. Rare complications of physical therapy treatments may include burns and or skin irritation/redness.

Reasonable alternatives to chiropractic care may include: over the counter analgesics, rest, medical care and prescription medication including pain medicine, anti-inflammatory, & muscle relaxers, or possibly surgery.

I hereby request and consent to the performance of chiropractic adjustments and other procedures by Dr. Miniaci and/or other licensed doctors of chiropractic who now or in the future may practice in, work or associate with, or be employed by Miniaci Chiropractic & Acupuncture LLC.

I have read the above consent, or had it read to me, have made my decision voluntarily and freely. To attest to my consent to these procedures I hereby affix my signature to this authorization for treatment.

_____ _____ _____
Patient's Name Printed Patient's Signature Date

Witness: _____ date _____

Patient Questions/Comments: _____
_____

COMPLETE FOLLOWING IF PATIENT IS A MINOR OR UNABLE TO CONSENT:

Patient name: _____ **Age:** _____
Name of person legally authorized to sign for patient: _____
Relationship: _____
Signature of authorized Person: _____ **Date:** _____

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By affixing my signature below, I am indicating that I understand and agree to the following policies of Miniaci Chiropractic & Acupuncture Center LLC:

Health and accident policies are an agreement between an insurance carrier and myself. The chiropractic office will assist me in the completion of any forms needed to assist me in collection from the insurance carrier, however, any fee for service is ultimately my responsibility. The chiropractic office will check my chiropractic benefits for me, however benefit verification is never a guarantee of either payment or coverage, and it is ultimately my responsibility to know my coverage/policy. Should my insurance carrier require a referral of any type, I am responsible for obtaining the referral as well as for making sure that the chiropractic office has received the referral; further, I am responsible for making sure that updated referrals, if needed, are provided to the chiropractic office in a timely manner. If I fail to verify a referral or, should a referral not be present at the time of the service, I am accepting full financial liability for service rendered. I further acknowledge that my insurance carrier may not offer a benefit sufficient to cover all of the visits needed, or that they may disallow certain services for which I will be responsible. Co-pays, coinsurance and deductibles are due at the time of service. Acceptable methods of payment are: cash, personal check, money order, debit/ATM cards, Visa, MasterCard, American Express, and Discover Card.

There is a $25.00 fee for appointments not cancelled with 24 hour notification.

I have been advised that the office will protect my personal health information in accordance with the HIPAA laws. I further acknowledge that I may receive a written copy of the office's HIPAA practices at any time, and that I acknowledge that my information, at times, will be shared with various other entities including but not limited to physicians, specialists, and insurance carriers for the purpose of coordinating care and collecting account balances.

My signature below further indicates: **I authorize the release of any medical or other information necessary to process my claims/bills. I also request payment of government benefits either to myself or the party who accepts assignment . I authorize payment of medical benefits to: Keith A. Miniaci, D.C., Miniaci Chiropractic & Acupuncture Center LLC.**

Signature_____ Date:_____

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AUTHORIZATION TO OBTAIN AND/OR DISCLOSE HEALTH INFORMATION

I hereby authorize _____ to disclose and/or obtain my individually identifiable health information as described her to the person/organization named below. I understand that this authorization is voluntary and that it **may include information relating to AIDS, HIV, infection, behavioral health services, psychiatric care, treatment for alcohol and/or drug abuse.**

Patient name: _____ DOB: _____

Information to be disclosed/obtained:

Service dates: _____

[] Initial evaluation/examination [] Emergency room records [] Daily Treatment notes
[] Intake paperwork [] Laboratory tests/results
[] Consultation reports [] Radiology films/reports
[] Entire record (Consideration will be given in releasing entire record only when a subsection to the record will not serve the intended purpose of this disclosure.)
[] Other (Specify):_____

DO NOT release the following information: _____

Name of person(s) /organization(s) to whom the disclosure is to be made or from whom the information is to be obtained:_____

I am requesting the information be disclosed for the purpose of: (for example: legal reasons, continued care, insurance, another medical opinion, Worker's compensation, Employment, research, personal usage, Social Security):_____.

I understand this authorization may be revoked IN WRITING at any time except to the extent that the action has already been taken in reliance on this authorization. This authorization shall automatically expire in 1 year from the date of signature unless otherwise specified in the space provided here:

EXPIRATION DATE: _____.

I understand I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. There may be a fee associated with copying, not to exceed what is allowed by Connecticut State Law (45 cents per page, plus the cost, if any, of postage).

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information listed to the extent indicated and authorized herein.

I understand that this provider may not condition treatment on the provision of this authorization except in cases of research related treatment protocols or studies being conducted by outside third parties through this provider. In such cases specific authorization for the research related treatment protocols /studies will be signed as a condition of participation.

NOTICE TO RECIPIENTS: As the recipient of this information you may use the information only for the stated purpose. You may disclose this information to another party ONLY :

- With written authorization from the patient or his or her legal representative;
- As required by state and or federal law
- If needed for the patient's continued care

If this disclosure contains information regarding HIV behavioral health, psychiatric, alcohol or drug abuse education training, treatment rehabilitation or research the following shall apply:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

NOTICE TO THE INDIVIDUAL REQUESTING DISCLOSURE:

Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan and the information disclosed is NOT protected by definition under current laws, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.

Patient/legal representative signature;_____ Date: _____