NEW CANAAN CHIROPRACTIC

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WELCOME

The doctor and staff of NEW CANAAN CHIROPRACTIC welcome you and want to provide you with the best possible care. We will conduct a thorough history to decide if we can assist you. If we do not believe that your condition will respond to the types of care provided at our office, we will not accept you as a patient, but will refer you to another health care provider, if appropriate.

Fee structure

In order to keep our services as affordable as possible, our office is on a **fee-for-service** basis. The initial visit is $270 for the first hour. Consultation times are divided up in 15-minute intervals. Any types of lab tests are an additional fee. **Payment is expected at the time of the visit.** A superbill receipt will be provided upon request. Unless canceled at least 24 hours in advance, our policy is to charge $60 for missed appointments. Please help us serve you better by keeping scheduled appointments. Please refer to our financial policy for additional payment information.

PATIENT IDENTIFICATION

Referred by_____

Name_____ Name/Nickname I prefer to be called in this office_____

Address_____ City/Zip Code_____

Telephone (Home)_____ (Work)_____ OK to call you at work? Yes / No

Email Address_____

Date of Birth _____ Age _____ Occupation _____

Employer_____

Male/Female Married/Single/Divorced/Widowed Name of Significant Other_____

Contact in case of emergency _____Telephone #_____

Name of Parent of Minor Patient (If applicable)_____

Your Medical Physician(s) _____

Previous Chiropractor_____ Problem & Outcome_____

I understand that I will be paying for all of my first visit charges. I understand the charges for treatment are usual and customary for our area. I understand that I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

_____ _____

Date Signature

PATIENT DIAGNOSTIC QUESTIONNAIRE

New Canaan Chiropractic

Name _____ How old are you? _____Today's Date _____

What is your heritage? (i.e. Irish, German, Spanish, etc.) _____

How much do you weigh? _____ What is your blood type? _____How tall are you? _____

YOUR CHIEF COMPLAINTS

Please mark with a (X) the principle or major conditions, which you are concerned about, would like eliminated, or desire treatment for:

001 ( ) Nutritional Evaluation
002 ( ) Thorough Diagnostic Checkup
003 ( ) Overweight
004 ( ) Underweight
005 ( ) Extreme Fatigue
006 ( ) Circulatory Problems
007 ( ) Heart Condition
008 ( ) Blood Pressure Problems
009 ( ) Digestion Trouble
010 ( ) Gall Bladder Problems
011 ( ) Stomach Problems
012 ( ) Intestine or Bowel Troubles
013 ( ) Diabetes Mellitus
014 ( ) Skin Problems
015 ( ) Allergies to Food
016 ( ) Allergies in General
017 ( ) Arthritis/ Rheumatism
018 ( ) Female Problems
019 ( ) Sexual Problems
020 ( ) Menopause Problems
021 ( ) Neck and/or Spine Problems
022 ( ) Lung and/or Breathing
023 ( ) Headaches
024 ( ) Sinus Infections
025 ( ) Ear or Hearing Disorders
026 ( ) Eye Condition
027 ( ) Nose/Throat/Mouth Problems
028 ( ) Kidney/Bladder/Urinary Problems
029 ( ) Cancer
030 ( ) Alcohol/Tobacco Addiction
031 ( ) Dizziness/Balance Disorder
032 ( ) Nervous/Emotional Trouble

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY WHEN COMPLETING THIS QUESTIONNAIRE:

Read each question carefully and mark with a **(X) only those statements which are true for you (a yes answer).**
If a question does not apply to you or you do not recognize the terminology or disease, or if you are not sure and have a doubt about a question, then do not check the box, simply leave it blank.

GENERAL

033 ( ) What time do you normally go to bed/awaken?
034 ( ) Do you feel rested upon awakening?
035 ( ) Do you awaken regularly between 2 and 3am?
036 ( ) Do you frequently experience a second wind (high energy) late at night?
037 ( ) Are you unable to recall your dreams the next day?
038 ( ) Do you have recurrent bad dreams?
039 ( ) Is your energy good all day?
040 ( ) What time of day is your energy best?
041 ( ) What time of day is your energy lowest?
042 ( ) Do you exercise?
If yes, what type, time of day, how long, how often?_____
If no, is there reason why you cannot exercise? _____
043 ( ) Do you smoke cigarettes each day or inhale pipe/cigars?
044 ( ) Do you drink alcoholic beverages each day?
045 ( ) Do you usually drink less than 8 glasses of water a day?
046 ( ) Are you sensitive to chemicals, paint, exhaust fumes, cologne?
047 ( ) Do you travel outside the U.S.?

EYES

048 ( ) Are you near sighted (can't see things at a distance)?
049 ( ) Are you far sighted (Can't read small print without glasses)?
050 ( ) Do your eyes frequently itch?
051 ( ) Do you suffer from cross-eyes?
052 ( ) Do you have or have you had cataracts or Glaucoma?
053 ( ) Do you experience pain in your eyes?
054 ( ) Are your eyes bloodshot?
055 ( ) Do your eyes water?
056 ( ) Do your eyes feel gritty?
057 ( ) Is your vision blurred?
058 ( ) Do you wear sunglasses when you are outdoors?
059 ( ) Does sunlight bother your eyes?

EARS

060 ( ) Are you hard of hearing?
061 ( ) Are you experiencing any discharge from your ears?
062 ( ) Do you have ringing or noises in your ears?
063 ( ) Do you suffer from recurrent ear infections?
064 ( ) Do you have a punctured eardrum?
065 ( ) Do loud noises (sounds) bother you?

MOUTH AND THROAT

066 ( ) Is your tongue badly coated?
067 ( ) Do you have bad breath?
068 ( ) Do you suffer from sores or cracks in the corners of your mouth?
069 ( ) Do you frequently experience canker sores (mouth sores)?
070 ( ) Are your gums sore?
071 ( ) Do you frequently suffer from fever blisters?
072 ( ) Do your gums bleed when you brush your teeth?
073 ( ) Do you have sore throats frequently?
074 ( ) Are your glands often swollen?
075 ( ) Do you suffer from toothaches?
076 ( ) Is your mouth often dry?
077 ( ) Do you have excessive saliva?
078 ( ) In the mornings do you have a bitter taste in your mouth?
079 ( ) Do you have a dental bridge in your mouth?
If yes, what material was used _____
080 ( ) Have you ever had any root canals?
If yes, how many and when? _____
081 ( ) Have you ever had any teeth extracted, including wisdom teeth?
If yes, when?_____
082 ( ) Do you have any fillings?
If yes, how many and what materials were used? _____
083 ( ) Do you use a dental splint?
If yes, what material was used? _____
084 ( ) Do you have TMJ (jaw) problems?
If yes, please describe: _____
085 ( ) Do you have or have you ever had braces?

RESPIRATORY

086 ( ) Do you have frequent colds?
087 ( ) Do you catch severe colds?
088 ( ) Do you suffer from nasal polyps?
089 ( ) Do you often have sinus infections?
090 ( ) Do you have postnasal drip?
091 ( ) Do you have hay fever?
092 ( ) Do you wheeze?
093 ( ) Do you have asthma?
094 ( ) Do you ever experience difficulty in breathing?
095 ( ) Do you have a chronic cough?
096 ( ) Do you spit up phlegm?
097 ( ) Do you spit up blood?
098 ( ) Do you have spells of sneezing?
099 ( ) Is your nose frequently stuffy?
100 ( ) Does your nose run constantly?
101 ( ) Do you have frequent nosebleeds?
102 ( ) Do you have a chronic chest condition?
103 ( ) Do you experience night sweats?

CARDIOVASCULAR

104 ( ) Do you have high blood pressure?
105 ( ) Do you have low blood pressure?
106 ( ) Do you have pains in the heart or chest?
107 ( ) Are you troubled with blood clots?
108 ( ) Do you have cold hands/feet?
109 ( ) Do you have varicose veins?
110 ( ) Are your ankles frequently swollen?
111 ( ) Do you have an unusually slow pulse rate?
112 ( ) Do you experience spells of rapid heartbeat?
113 ( ) Are you aware of your heart skipping beats?
114 ( ) Do you experience shortness of breathe while sitting still?
115 ( ) Do you suffer from leg cramps after retiring to bed?
116 ( ) Do you suffer from leg cramps during the day?
117 ( ) Do you experience pain in your legs/hips when walking?

GASTROINTESTINAL

118 ( ) Is your appetite poor?
119 ( ) Do you have excessive hunger?
120 ( ) Do you experience fainting spells when hungry?
121 ( ) Does eating relieve fatigue?
122 ( ) Do you feel shaky when hungry?
123 ( ) Are you frequently drowsy after eating a meal?
124 ( ) Do you eat when nervous?
125 ( ) Do you have difficulty swallowing?
126 ( ) Do you vomit frequently?
127 ( ) Are you frequently nauseated?
128 ( ) Are you bloated after eating?
129 ( ) Do you have abdominal gas?
130 ( ) Does eating greasy foods cause you to have indigestion?
131 ( ) Do you belch or burp after eating?
132 ( ) Do you have: indigestion immediately upon eating?
133 ( ) indigestion within 1 hour after meals?
134 ( ) indigestion 2 or more hours after meals?
135 ( ) Do you frequently have diarrhea?
136 ( ) Do you have loose bowel movements?

137 ( ) Have you ever had intestinal worms?
138 ( ) Do you have pale or yellow colored stools?
139 ( ) Do you suffer from constipation?
140 ( ) Do you have one or less bowel movements daily?
141 ( ) Are you stools bloody?
142 ( ) Do you have black tarry stools?
143 ( ) Do you use laxatives?
144 ( ) Do you suffer from severe abdominal pains?
145 ( ) Do you have any hemorrhoids (piles)?
146 ( ) Do you have or have you ever had stomach ulcers?
147 ( ) Do you have or have you ever had gall bladder disease?
148 ( ) Do you have or have you ever had liver disease?

NEUROMUSCULAR

149 ( ) Do you have neck pain?
150 ( ) Do you have pain between the shoulders?
151 ( ) Do you suffer from low back pain?
152 ( ) Do you have swollen joints?
153 ( ) Do you have a spinal curvature? (Scoliosis/Kyphosis)
154 ( ) Do you suffer from muscle spasms?
155 ( ) Are your muscles frequently sore?
156 ( ) Do you have muscle weakness?
157 ( ) Are your joints stiff in the morning?
158 ( ) Do you have shoulder or arm pain?
159 ( ) Do you suffer from leg pain at rest?
160 ( ) Does any part of your body experience numbness or tingling?
161 ( ) Do you have frequent headaches?
162 ( ) Are you often dizzy?
163 ( ) Do you suffer from motion sickness?
164 ( ) Do you frequently feel faint?
165 ( ) Do you have epilepsy?
166 ( ) Do you bite your nails badly?
167 ( ) Do you stutter or stammer?
168 ( ) Are you a sleepwalker?
169 ( ) Do you have rheumatism?
170 ( ) Do you have rheumatoid arthritis?
171 ( ) Do you have osteoarthritis?

Please list all head, neck or back injuries:

_____
_____
_____

URINARY

172 ( ) Do you have frequent urination?
173 ( ) Do you awaken at night to urinate?
174 ( ) Are you a bed wetter?
175 ( ) Do you dribble when sneezing or laughing?
176 ( ) Have you ever lost control of your bladder?
177 ( ) Do you have painful urination?
178 ( ) Do you have blood in your urine?
179 ( ) Are you troubled by urgent urination?
180 ( ) Do you have difficulty in starting the stream?
181 ( ) Do you have or have you ever had frequent bladder infections?
182 ( ) Do you have or have you ever had frequent kidney infections?
183 ( ) Do you have or have you ever had kidney stones?

ENDOCRINE

184 ( ) Do you have excessive thirst?
185 ( ) Do you frequently feel cold?
186 ( ) Do you frequently feel hot?
187 ( ) Are you unusually tired most of the time?
188 ( ) Are you unusually jumpy or nervous?
189 ( ) Is you hair coarse?
190 ( ) Is your skin coarse?
191 ( ) Are you diabetic?
192 ( ) Do you get lightheaded when standing quickly?

FEET

193 ( ) Do you suffer from painful feet?
194 ( ) Do you have frequent foot cramps?
195 ( ) Do you have plantar warts?
196 ( ) Do you have heal spurs?
197 ( ) Are you troubled with corns or bunions?

SKIN

198 ( ) Is your skin tender?
199 ( ) Does your skin itch?
200 ( ) Do you have skin eruptions?
201 ( ) Is your skin rough, especially on the back of your arms?
202 ( ) Do you have Psoriasis?
203 ( ) Do you bruise easily?
204 ( ) Do you have Acne?
205 ( ) Are you troubled by boils?
206 ( ) Do you have Eczema?
207 ( ) Are you aware of any moles which are changing in size or color?
208 ( ) Do you frequently experience goose bumps?
209 ( ) Do you have hives (allergy reaction of the skin)?
210 ( ) Do you have excessive perspiration?
211 ( ) Do you get sores that are slow to heal?
212 ( ) Are your fingernails ridged or have white spots?

FOR WOMEN ONLY (Menarche= _____ years old)

213 ( ) Do you have painful periods?
214 ( ) Do you have an excessive flow?
215 ( ) Do you have irregular cycles?
216 ( ) Do you suffer from menstrual cramps?
217 ( ) Do you retain fluid during your periods?
218 ( ) Do you have tender breasts?
219 ( ) Do you have vaginal discharge?
220 ( ) Do you have any bloody spotting discharge?
221 ( ) Have you had a hysterectomy?
222 ( ) Have you ever miscarried?
223 ( ) Do you have acne worse at menstruation?
224 ( ) Do you have frequent yeast infections?
225 ( ) Do you have lumps in your breasts?
226 ( ) Do you have heavy hair growth on face or body?
227 ( ) Do you take birth control pills?
228 ( ) Do you have pre-menstrual depression?
229 ( ) Is intercourse painful to you?
230 ( ) Do you have a diminished sex desire?
231 ( ) Do you have poor or infrequent orgasm?

FOR MEN ONLY

232 ( ) Do you have painful genitals?
233 ( ) Do you have prostate troubles?
234 ( ) Do you have lumps in your testicles?
235 ( ) Do you have a discharge from your urethra?
236 ( ) Do you have sores on external genitalia?
237 ( ) Do you have difficulty getting or keeping an erection?
238 ( ) Do you have difficulty completing intercourse?
239 ( ) Have you had difficulty fathering children?

BEHAVIORAL

240 ( ) Do you have difficulty falling/staying asleep?
241 ( ) Do you have difficulty in concentrating?
242 ( ) Is your memory poor?
243 ( ) Do strange people or places make you afraid?
244 ( ) Are you scared to be alone?
245 ( ) Do you frequently get scared for no reason?
246 ( ) Do you always need someone to advise you?
247 ( ) Are you afraid to eat anywhere except at home?
248 ( ) Are you unhappy when others are happy?
249 ( ) Do you often cry?
250 ( ) Are you frequently miserable or blue?
251 ( ) Do you sometimes wish you were dead or away from it all?
252 ( ) Are your feelings hurt easily?
253 ( ) Does criticism always upset you?
254 ( ) Do people usually misunderstand you?
255 ( ) Do you have to be on guard even with your friends?
256 ( ) Do people often annoy you?
257 ( ) Are you easily angered?
258 ( ) Do you suffer from depression?
259 ( ) Are you usually unhappy or depressed?
260 ( ) Do you feel you are under considerable emotional/mental stress?
How long have you felt this way? _____

Please answer the following questions as thoroughly as you can.

FOOD ROUTINE

261 Do you suffer from low blood sugar? YES / NO if yes, please explain: _____
262 How many meals (including snacks) do you eat a day? _____
263 How much time between meals/snacks? _____
264 Do you eat within 1 hour of awakening? YES / NO
If no, how long after awakening until you eat you first meal? _____
265 Do you have a bedtime snack? YES / NO If yes, please describe: _____
If no, how many hours between dinner and bedtime? _____
266 Please describe a typical day's meals and snacks from awakening until bedtime (ending your day).
Breakfast (time _____)_____
Lunch (time _____)_____
Dinner/Supper (time _____)_____
Snack (time _____)_____
Snack (time _____)_____
Snack (time _____)_____
267 Do you frequently skip meals? YES / NO
268 Do you need caffeine (coffee, tea, etc.) to get you going in the morning? YES / NO

MEDICATIONS/SUPPLEMENTS

269 Do you take any medications? (e.g.: High blood pressure, Thyroid hormones, other hormones, anti-depressants, sleeping medication, etc.) YES / NO If yes, please list type, dosage, what they are for, and how long you have been taking them?

_____
_____
_____
_____

270 Are you currently taking any nutritional supplements? YES / NO If yes, please list all products and daily dosages:

_____
_____
_____
_____

DAILY ROUTINE

271 What is your daytime light source? (i.e. indoor/outdoor, fluorescent, full spectrum, etc.) _____

272 How much time do you get outdoor light (direct or indirect) daily? _____

273 Describe any believed exposure(s) to environmental and/or chemical toxins: _____

_____
_____
_____
_____

274 Describe your hobbies and forms of recreation: _____

_____
_____
_____
_____

275 How long has it been since you have felt your best?_____

Thank you for completing this questionnaire.

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information. **164.506 (c)(1)**

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). **164.506 (c)(2)** We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices. **164.506 (c)(3)**

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. **164.506 (c)(4)(i)** If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. **164.506 (c)(4)(ii)** However, if we agree with your restrictions, the restriction is binding on us. **164.506(c)(4)(iii)**

Your right to revoke your authorization \

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. 164.506 (c)(5) If 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. 164.508(b)(5)(ii)

I have read your consent policy and agree to it terms. I am also acknowledging that I have a right to receive a copy of this notice.

Printed Name	Authorized Provider Representative
Signature	Date
Date	