

# 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 \$230 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 \$30 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 \_\_\_\_\_

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

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### **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 your 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 heel 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 your 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?

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

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**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: \_\_\_\_\_

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274 Describe your hobbies and forms of recreation: \_\_\_\_\_

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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