Patient Registration Information

Legal Name _____

Address _____

City _____ **State** _____ **Zip code** _____

Home Phone _____ **Cell Phone** _____ **Text Msg? Y N**

Email address _____

Sex ☐ Male ☐ Female **Age** _____ **Birthdate** _____

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Parents (if minor) _____ **Spouse/Partner name** _____

Children (names & ages) _____

Occupation _____ **Employed by** _____

Activities at Work _____

How did you hear about Dr. Cayer? ☐ Returning Patient ☐ Internet/Website ☐ Lecture Series

☐ Yellow Pages ☐ Newspaper ad ☐ Restaurant/Church flyer ☐ Friend/ Family ☐ Other

If Friend/Family or Other, please comment _____

Primary Insurance

Copy of photo ID and insurance card will be requested at initial visit

Policy Subscriber _____ **Birthdate** _____

Relation to Patient _____ **Employer** _____

Insurance Company _____ **Policy Renewal date** _____

Additional Insurance

Is the patient covered by additional insurance? ☐ yes ☐ no

Subscriber name _____ **Ins. Company** _____

Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Cayer all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of my benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges, whether or not covered by the insurance.

_____ _____ _____

Responsible Party Signature Relationship to Patient Date

Dr. Cayer's Pain Relief & Holistic Health Center
97 South Main Street, Suite 11 Newtown, CT 06470
203 426 4700

PATIENT HEALTH QUESTIONNAIRE

Name _____ Date: M____/D ____/Y _____

PRESENT COMPLAINTS. PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

In the space below, please describe the present complaint(s) which brought you to this clinic for care. After completing this first section, please complete the questionnaire on the reverse side. The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

1. Present complaint _____

_____

2. Please describe the character of your current pain (YOU MAY CHECK ONE OR MORE ANSWERS):

❑ Sharp Stabbing ❑ Sharp/Dull ❑ Aches ❑ Dull ❑ Soreness ❑ Weakness ❑ Throbbing/Gnawing ❑ Numbness ❑ Shooting ❑ Gripping/Constricting ❑ Burning ❑ Tingling

3. How often are the complaints present? ❑ Constant (76-100%) ❑ Frequent (51-75% ❑ Occasional (26-50%❑ Intermittent (25% or less)

4. How bad is your pain or ache? Please circle a number? 0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

5. Since your problem began is the pain: ❑ Increasing ❑ Decreasing ❑ Not Changing

6. When did your problem begin: SPECIFIC DATE IF POSSIBLE: _____

7. Did your problem begin: ❑ Immediately after a specific incident ❑ Multiple incidents ❑ Gradually develop over time ❑ No specific reason

8. Describe how your problem began _____

_____

9. What treatment have you received for this present condition? ❑ Surgery ❑ Spinal injections ❑ Therapy from a PT ❑ A back support

10. Were you previously treated for a different occurrence of this same condition? ❑ yes ❑ no If yes by: ❑ Chiropractor ❑ MD ❑ Therapist ❑ Other: _____ (SPECIFY DATES & TYPE OF TREATMENT WITH RESULTS): _____

_____

11. What makes your problem better? ❑ Nothing ❑ Lying Down ❑ Walking ❑ Standing ❑ Sitting ❑ Movement Exercise ❑ Inactivity ❑ Other _____

12. What makes your problem worse? ❑ Nothing ❑ Lying Down ❑ Walking ❑ Standing ❑ Sitting ❑ Movement Exercise ❑ Inactivity ❑ Other _____

13. How would you grade your general stress level? ❑ No Stress ❑ Minimal Stress ❑ Moderate Stress ❑ Greatly Stressed

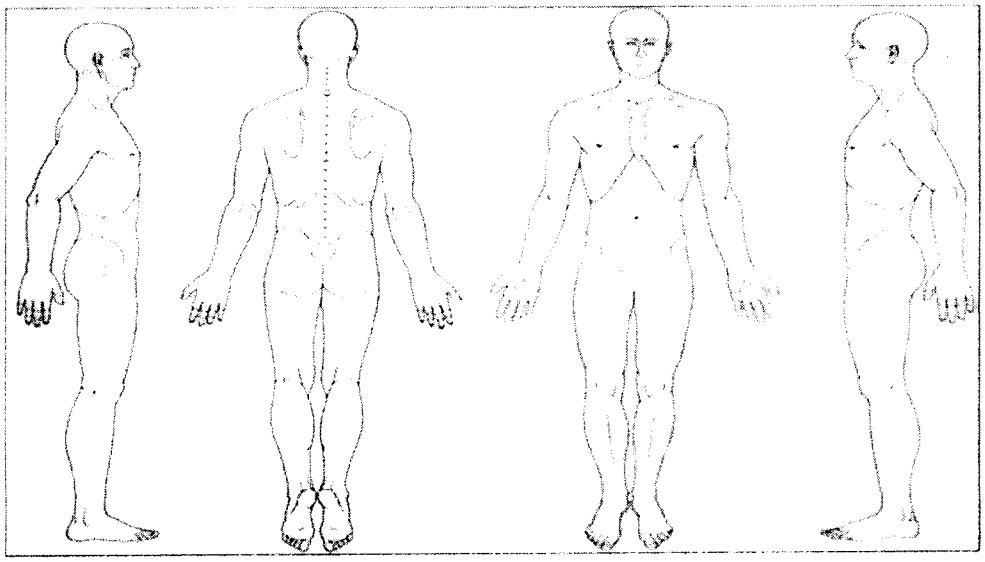
14. Physical activity at work? ❑ Sitting More Than 50% of the workday ❑ Light Manual Labor ❑ Manual Labor ❑ Heavy Manual Labor

15. General physical activity: ❑ No Regular Exercise Program ❑ Light Exercise Program ❑ Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active?

❑ No effect.
❑ Some physical restrictions (able to perform light duty work and household tasks).
❑ Need limited assistance wih common everyday tasks
❑ Need assistance often.
❑ Have a significant inability to function without assistance
❑ Am totally disabled (impaired). Cannot care for self

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS, INCLUDING SYMPTOMS OF PAIN, NUMBNESS OR TINGLING.



SYMPTOMS LIST: Please check any symptoms you have from the list below. Date: _____

Your Name: _____

HEAD:

_____1. Headache
_____2. sinus (allergy)
_____3. entire head
_____4. back of head
_____5. forehead
_____6. temples
_____7. migraine
_____8. frequent and severe
_____ 9. Head feels heavy
_____10. Lightheadedness
_____11. Fainting
_____12. Face flushed
_____13. Loss of memory
_____14. Eye strain
_____15. Light bothers eyes
_____16. Blurred vision
_____17. Double vision
_____18. Loss of vision
_____19. Loss of balance
_____20. Dizziness
_____21. Loss of hearing
_____22. Pain in the ears
_____23. Ringing in the ears R L
_____24. Buzzing in the ears R L
_____25. Loss of taste
_____26. Loss of smell
_____27. Sinus trouble

NECK:

_____30. Neck pain
_____31. Neck stiffness
_____32. Neck pain and stiffness
_____33. Moderate to severe neck pain
_____34. Neck pain with movement
_____35. forward
_____36. backward
_____37. turning to the left
_____38. turning to the right
_____39. bending to the left
_____40. bending to the right
_____41. Pinched nerve in the neck
_____42. Neck feels "out of place"
_____43. Muscle spasms in the neck
_____44. Grinding sounds in the neck
_____45. Arthritis in the neck

SHOULDERS:

_____50. Pain in shoulder joint R L
_____51. Pain across shoulders
_____52. Pain between shoulder blades
_____53. Stiffness in shoulder R L
_____54. Tension in the shoulders
_____55. Pinched nerve - shoulder R L
_____56. Muscle spasms - shoulder R L
_____57. Unable to raise arm R L
_____58. above shoulder level R L
_____59. over head R L

ARMS & HANDS:

_____65. Pain in the upper arm R L
_____66. Pain in the elbow R L
_____67. Tennis elbow R L
_____68. Pain in forearm R L
_____69. Pain in hands R L
_____70. Pain in fingers of R L hand
_____71. Sensation of pins & needles in the arm R L
_____72. Sensation of pins & needles in the fingers R L
_____73. Numbness in arms R L
_____74. Numbness in fingers R L
_____75. Fingers go to sleep R L
_____76. Hands get cold
_____77. Swollen joints in fingers
_____78. Stiffness in fingers R L
_____79. Loss of grip strength R L

MID-BACK:

_____82. Mid-back pain
_____83. Mid-back stiffness
_____84. Mid-back pain and stiffness
_____85. Mid-back muscle spasms
_____86. Pain in kidney area

CHEST:

_____90. Chest pain
_____91. Shortness of breath
_____92. Pain around the ribs
_____93. Breast pain
_____94. Irregular heartbeat

ABDOMEN:

_____100. Nervous stomach
_____101. Nausea
_____102. Gas
_____103. Constipation
_____104. Diarrhea
_____105. Hemorrhoids

LOW BACK:

_____110. Low back pain
_____111. Low back stiffness
_____112. Low back pain and stiffness
Low back pain is worse when:
_____114. working
_____115. lifting
_____116. stooping
_____117. standing
_____118. sitting
_____119. bending
_____120. coughing
_____121. lying down (sleeping)
_____122. walking
_____125. Low back feels out of place
_____126. Muscle spasms in low back

HIPS, LEGS & FEET:

_____130. Pain in buttocks R L
_____131. Pain in the hip joint R L
_____132. Pain down the leg R L
_____133. Pain down both legs
_____134. Leg cramps R L
_____135. Cramps in feet R L
_____136. Knee pain R L
_____137. inside R L
_____138. outside R L
_____139. Pins & needles in legs R L
_____140. Numbness of leg R L
_____141. Numbness of feet R L
_____142. Numbness of toes R L
_____143. Swollen ankles R L
_____144. Swollen feet R L
_____145. Feet feel cold

WOMEN ONLY:

_____150. Menstrual pain (where) _____
_____151. Menstrual cramping
_____152. Irregular period
_____153. Abnormal discharge
_____155. Tumors

MEN ONLY:

_____160. Urinary frequency
_____161. Difficulty in starting urination
_____162. Night urination
_____163. Prostate pain/swelling

GENERAL:

_____170. Anxiety
_____171. Nervousness
_____172. Irritable
_____173. Difficulty in prolonged riding in an automobile
_____174. Depression
_____175. Fatigue
_____176. Generally feel run down
_____177. Difficulty sleeping
_____178. Loss of weight _____lbs.
_____179. Gain weight _____lbs.
_____180. Excessive perspiration
_____181. Pallor
_____182. Tremors

Write in your own symptoms: _____

Have you ever had any falls, auto accidents, or injuries? Yes ____ No ____ Please Describe	Age at time or month and year	Type of accident / briefly describe	Treatment and/or Complications

Have you had surgery or been hospitalized? Yes ____ No ____ Please Explain	Age at time or month and year	Type of surgery or reason for hospitalization	Complications, if any and/or Comments

Have you ever dislocated, fractured or broken any bones? Yes ____ No ____ Please Describe	Age at time or month and year	Area involved / which bone(s)	Associated with what injury

Have you ever suffered from a major or lengthy illness? (childhood and adult) Yes ____ No ____ Please Explain	Age at time or month and year	Illness	Complications if any and/or comments

Date of last physical exam? ____ Reason for exam and results: ____

Date of most recent x-rays? ____ Area(s) x-rayed and reasons: ____

Are you presently taking medications or drugs? Yes ____ No ____ Please List	Name of drug(s)	Doses/Day	Length of time taking and for what condition

Do you take vitamins or minerals? Yes ____ No ____ Please List	Type/Brand	Amount/Frequency

Do you wear heel lifts? Yes ____ No ____ Arch supports? Yes ____ No ____ Sole lifts? Yes ____ No ____ Inner soles? Yes ____ No ____

Have you ever had a spinal tap or spinal injection? Yes ____ Date ____ No ____

Were you ever knocked unconscious? Yes ____ Date(s) ____ No ____

If female, are you, or is it possible that you may be pregnant now? Yes ____ No ____

Do you suffer from any conditions other than those which you are now consulting this office for?

Yes ____ Please explain ____ No ____

Habits:	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				

Habits: (Cont.)	Heavy	Moderate	Light	None
Exercise				
Sleep				
Appetite				

Acknowledgement of Notice of Privacy Practices

You are NOT required to sign this form

HIPPA Privacy Rules require that this form be retained by the medical provider, regardless if signed by the patient. This form has been created to inform patients of their right to receive a copy of the Notice of Privacy Practices and give an overview of some of the ways in which their personal health information may be used.

I, _____ understand that Dr. Cayer's Chiropractic Center (referred to below as "the Center") will use and disclose health information about me in the course of providing care to me.

I understand that my health information may include information both created and received by the Center, may be in the form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar health-related information.

I understand that the Center is permitted to use and disclose my health information in order to

- make decisions about and plan for my care and treatment
- refer to or consult and coordinate with other health care providers in the course of my treatment
- determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- perform various office, administrative, and business functions that support the Center's ability to provide me with the appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices (NPP) may be revised from time to time and that I am entitled to receive a copy of any revised NPP upon request.

I understand that the NPP describes how I can exercise my right to ask that some or all my health information not be used or disclosed, and I understand that the Center is not required by law to agree to such requests.

By signing below, I acknowledge that I have received or been offered a copy of the Center's Notice of Privacy Practices.

_____ _____

Patient Signature Date

-OR-

_____ _____

Signature of Patient Representative Date

NOTICE OF PRIVACY PRACTICES

Eugene Cayer D.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.