



14 State Street | Seneca Falls, NY 13148 | (315) 712-4104

**Patient Information**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_

I prefer to be called by \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

**Payment / Insurance Information:**

**Who is responsible for your bill?**

\_\_\_\_\_ Self / Cash                      \_\_\_\_\_ Worker's Comp                      \_\_\_\_\_ Medicare

\_\_\_\_\_ Health Insurance                      \_\_\_\_\_ Auto Ins / No Fault                      \_\_\_\_\_ Spouse

\_\_\_\_\_ Other \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_

Member ID # (include letters) \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Have you filed an injury report with your employer? Yes \_\_\_\_\_ No \_\_\_\_\_

{Please notify the Front Desk Staff if your injury is a result of a work-related injury or auto accident and complete the appropriate paperwork}

How did you hear about us? \_\_\_\_\_

# STANTON CHIROPRACTIC

## PATIENT CONSENT FOR USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, \_\_\_\_\_, hereby state that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing of this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for the treatment and to carry out its healthcare operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the practice:
  - a) A postcard mailed to me at the address provided by me; and
  - b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its healthcare specific operations.
5. I understand that I have the right to request that the Practice restrict how my PHI is used/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

Name of Individual (Printed)

Signature of Individual

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Legal Representative\*

Relationship

Date Signed: \_\_\_ / \_\_\_ / \_\_\_ Witness: \_\_\_\_\_

\*Attorney-In-Fact, Guardian, Parent if minor

Medical Intake Form

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you had previous Chiropractic Care: Yes \_\_\_ No \_\_\_

Do you exercise weekly: Yes \_\_\_ No \_\_\_

Do you smoke: Yes \_\_\_, if so how often \_\_\_\_\_ No \_\_\_\_\_

Do you drink alcohol: Yes \_\_\_, if so how often \_\_\_\_\_ No \_\_\_\_\_

Do you use or have you used recreational drugs: Yes \_\_\_, if so how often \_\_\_\_\_ No \_\_\_\_\_

Hospitalizations (include year and reason): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any X-rays / MRI / CT Scans (include year and location) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List of Medications (if you have a copy of your medications, the front desk staff can make a copy for our records, otherwise, please list medications below): \_\_\_\_\_  
\_\_\_\_\_

Surgeries: (Please circle all that apply)

- |              |               |                 |                 |        |
|--------------|---------------|-----------------|-----------------|--------|
| Hysterectomy | Heart Bypass  | Cholecystectomy | Tonsillectomy   | Sinus  |
| Appendectomy | Cataract      | Hiatal Hernia   | Inguinal Hernia | Lasix  |
| Skin Cancer  | Carpal Tunnel | Neck Surgery    | Back Surgery    | Biopsy |

Arthroscopic Surgery  
Hip Replacement (L / R / Both)      Knee Replacement (L / R / Both)  
Other \_\_\_\_\_

Allergies: (Please circle all that apply)

- Sulpha      Penicillin      Dairy      Gluten      Nuts      Seasonal      Latex      Bees  
Other: \_\_\_\_\_

**Medical Information: to the best of your knowledge, do you have or have had:**

**Organs:**

- |                                              |                                            |                                                   |
|----------------------------------------------|--------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Aneurysms           | <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Asthma                   |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack      | <input type="checkbox"/> Pacemaker                |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Sarcoidosis              |
| <input type="checkbox"/> Sinus Surgery       | <input type="checkbox"/> Sleep Apnea       | <input type="checkbox"/> Shortness of Breath      |
| <input type="checkbox"/> Abdominal Pain      | <input type="checkbox"/> Constipation      | <input type="checkbox"/> Change in Appetite       |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Kidney Stones     |                                                   |

**Disease/Symptoms:**

- |                                          |                                               |                                                             |
|------------------------------------------|-----------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Raynaud's       | <input type="checkbox"/> Chron's Disease      | <input type="checkbox"/> Systematic Lupus Erythematosus     |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sjogren's Syndrome                 |
| <input type="checkbox"/> Lyme Disease    | <input type="checkbox"/> Diverticulitis       | <input type="checkbox"/> Multiple Sclerosis                 |
| <input type="checkbox"/> Cholecystitis   | <input type="checkbox"/> Thyroid Disease      | <input type="checkbox"/> Peripheral Vascular Disease        |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Gout <input type="checkbox"/> Gerd |
| <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> IBS                  | <input type="checkbox"/> Liver Disease                      |
| <input type="checkbox"/> Pancreatitis    | <input type="checkbox"/> Ulcerative Colitis   | <input type="checkbox"/> Ulcers                             |
| <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Diabetes                           |
| <input type="checkbox"/> HIV/AIDS        | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Blood Clots                        |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Bruising             | <input type="checkbox"/> Headaches                          |
| <input type="checkbox"/> Leukemia        | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Bell's Palsy                       |

**Have you Had or Do You Have:**

- |                                            |                                                               |                                            |                                             |                                        |
|--------------------------------------------|---------------------------------------------------------------|--------------------------------------------|---------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Stents            | <input type="checkbox"/> Stroke                               | <input type="checkbox"/> TIA (mini stroke) | <input type="checkbox"/> Sinusitis          | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Cataract(s)       | <input type="checkbox"/> Numbness                             | <input type="checkbox"/> Visual Changes    | <input type="checkbox"/> Retinal Detachment |                                        |
| <input type="checkbox"/> Tumors            | <input type="checkbox"/> History of Chemotherapy or Radiation |                                            |                                             |                                        |
| <input type="checkbox"/> STD               | <input type="checkbox"/> Urination (blood)                    | <input type="checkbox"/> Head Injury       |                                             |                                        |
| <input type="checkbox"/> History of Trauma | <input type="checkbox"/> Scleroderma                          | <input type="checkbox"/> Skin Rash         | <input type="checkbox"/> Shingles           |                                        |

**Females:**

- |                                        |                                             |                                           |                                       |
|----------------------------------------|---------------------------------------------|-------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Tubal Ligation     | <input type="checkbox"/> Abnormal periods | <input type="checkbox"/> Breast Lumps |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Uterine Fibroids   | <input type="checkbox"/> Menopause        | <input type="checkbox"/> C-Section    |
| <input type="checkbox"/> Pregnancy     | <input type="checkbox"/> Currently Pregnant |                                           |                                       |

**Males:**

- |                                    |                                          |                                               |
|------------------------------------|------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Prostate Hypertrophy |
|------------------------------------|------------------------------------------|-----------------------------------------------|

**Family History:**

- |                                               |                                   |                                       |                                    |                                         |
|-----------------------------------------------|-----------------------------------|---------------------------------------|------------------------------------|-----------------------------------------|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Rheumatoid Arthritis |                                   | <input type="checkbox"/> Back Surgery |                                    |                                         |

## History Questionnaire

In your own words, what is your chief complaint that brings you in today?

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Have you had more than one episode of pain or symptoms? Yes \_\_\_ No \_\_\_

If yes, how often does the episode occur? \_\_\_\_\_

If yes, how much time between episodes? \_\_\_\_\_

If yes, are the episodes **increasing** or **decreasing** or **the same** in intensity? (circle one)

What caused the pain to start? \_\_\_\_\_

When did it start? \_\_\_\_\_

Where do you feel the pain? \_\_\_\_\_

Has the pain spread? (if yes, to where) \_\_\_\_\_

What makes the symptoms worse? AM or PM (circle one)

Sitting       Walking       Rising       On the move  
 Standing       Lying       Rest

What makes the symptoms better? AM or PM (circle one)

Sitting       Walking       Rising       On the move  
 Standing       Lying       Rest

How would you describe your pain?

Cramping, dull aching       Sharp, shooting       Constant  
 Burning, pressure, stinging, aching       Deep, nagging, dull       Intermittent  
 Sharp, bright, lighting like       Throbbing, diffuse       Occasional

Do you experience any of the following symptoms, and where?

Numbness: \_\_\_\_\_

Tingling: \_\_\_\_\_

Weakness: \_\_\_\_\_

Have you received any treatment for this complaint? Yes or No (circle one)

If yes what treatment? \_\_\_\_\_

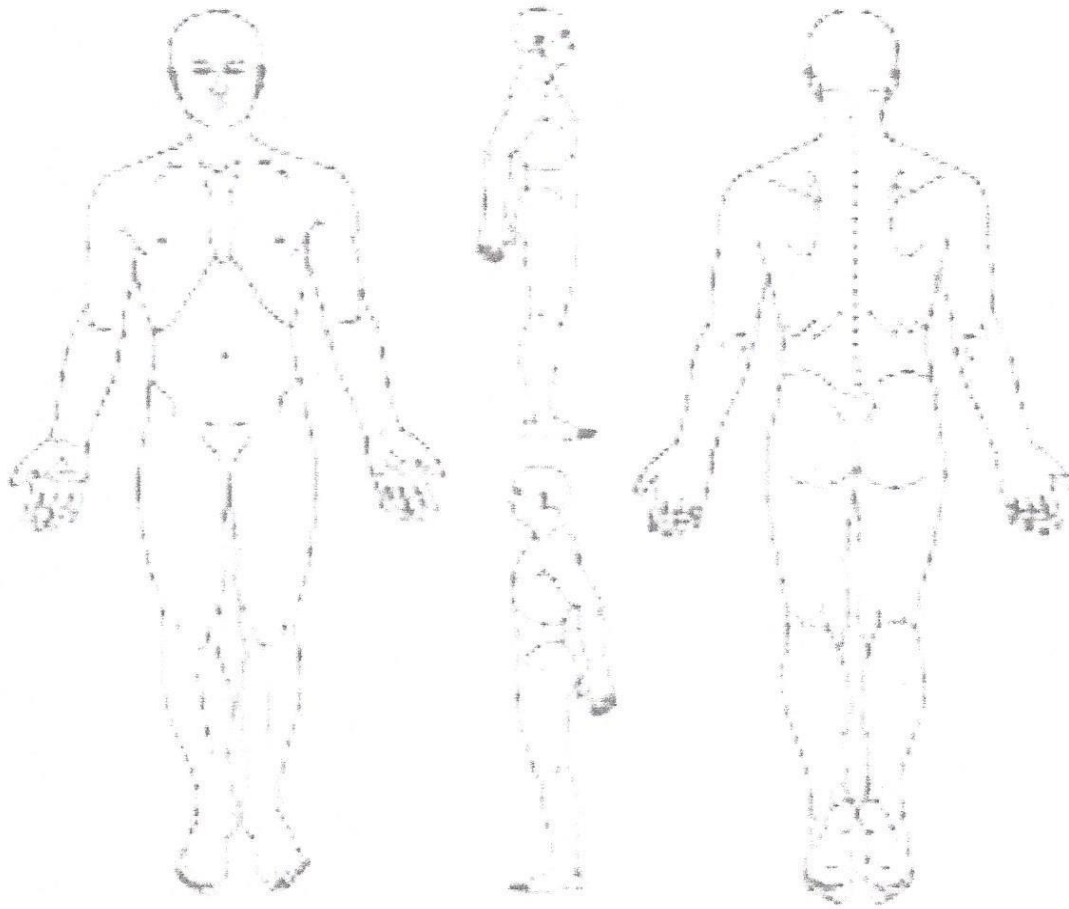
Did it help? Yes or No (circle one)

If you were involved in an accident, describe WHEN and HOW it happened \_\_\_\_\_

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Is this a work-related injury / did it happen at work? Yes or No (circle one)

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing?  
0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #10:

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What type of treatment are you looking for?

I am looking for the most minimal amount of care to “patch up the symptoms” of my problem

I am looking to resolve my symptoms and then go on to “fix the cause” of my problem

I am looking to take care of my problem and then go on to “achieve optimal Health & Wellness”



Regional Health Information Organization

# Authorization for Access to Patient Information Through a Health Information Exchange Organization

New York State Department of Health

**Provider** Stanton Chiropractic

|              |               |                               |
|--------------|---------------|-------------------------------|
| Patient Name | Date of Birth | Patient Identification Number |
|--------------|---------------|-------------------------------|

|                 |
|-----------------|
| Patient Address |
|-----------------|

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at [www.RochesterRHIO.org](http://www.RochesterRHIO.org).

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

**The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.**

|                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>My Consent Choice.</b> ONE box is checked to the left of my choice.<br/>         I can fill out this form now or in the future.<br/>         I can also change my decision at any time by completing a new form.</p> |                                                                                                                                                                                                                                                                                                            |
| <input type="checkbox"/>                                                                                                                                                                                                   | <p><b>I GIVE CONSENT</b> for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).</p>             |
| <input type="checkbox"/>                                                                                                                                                                                                   | <p><b>DENY CONSENT</b> for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, <b>even</b> in a medical emergency (except for minor patients).</p> |

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at [www.RochesterRHIO.org](http://www.RochesterRHIO.org) or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

|                                                        |                                                                 |
|--------------------------------------------------------|-----------------------------------------------------------------|
| Signature of Patient or Patient's Legal Representative | Date                                                            |
| Print Name of Legal Representative (if applicable)     | Relationship of Legal Representative to Patient (if applicable) |

## Details about the information accessed through Rochester RHIO and the consent process:

- 1. How Your Information May be Used.** Your electronic health information will be used only for the following healthcare services:
  - **Treatment Services.** Provide you with medical treatment and related services.
  - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
  - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
  - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.
- 2. What Types of Information about You Are Included.** If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:
  - Alcohol or drug use problems
  - Birth control and abortion (family planning)
  - Genetic (inherited) diseases or tests
  - HIV/AIDS
  - Mental health conditions
  - Sexually transmitted diseases
- 3. Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at [www.RochesterRHIO.org](http://www.RochesterRHIO.org) or by calling 1-877-865RHIO(7446).
- 4. Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.
- 5. Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.
- 6. Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: \_\_\_\_\_; or visit Rochester RHIO's website: [www.RochesterRHIO.org](http://www.RochesterRHIO.org); or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.
- 7. Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.
- 8. Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.
- 9. Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.