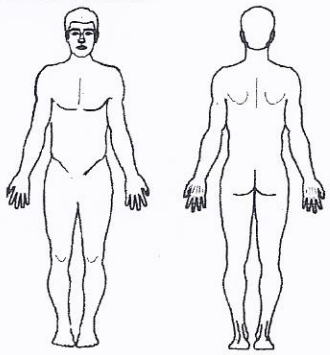
INITIAL HEALTH STATUS

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

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



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date)_____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain)_____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain)_____
_____
_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
_____
_____
☐ Medications_____
_____
_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

MEDICAL HISTORY FORM

Name: _____ **Age:** _____ **Date of Birth:** _____ **Date:** _____

I. PAST MEDICAL HISTORY

a. Surgeries

i. Type: _____ Date Performed: _____
ii. Type: _____ Date Performed: _____
iii. Type: _____ Date Performed: _____
iv. Type: _____ Date Performed: _____

b. Fractures

i. Type: _____ Date Performed: _____
ii. Type: _____ Date Performed: _____
iii. Type: _____ Date Performed: _____
iv. Type: _____ Date Performed: _____

c.ER Visits

i. Type: _____ Date Performed: _____
ii. Type: _____ Date Performed: _____
iii. Type: _____ Date Performed: _____

II. FAMILY HISTORY

a. Mother: Age *(if living)* _____ Age *(at death)* _____ Cause of death
List any medical Problems she had or lived with: _____

_____

_____

b. Father: Age *(if living)* _____ Age *(at death)* _____ Cause of death
List any medical Problems he had or lived with: _____

_____

_____

III. LIFESTYLE HISTORY

a. Have you ever been pregnant? Yes No N/A
If yes, how many births? _____ Cesarean Birth? Yes No
Any complications: _____

b. Current Smoker? Yes q No q *(If yes how long _____)*
ex-smoker? Yes No *(If yes how long did you smoke _____ When you quit_____)*

REVIEW OF SYSTEMS AND CONDITIONS

a. Have you had or presently have any of the following conditions? *(Please check and date)*

CONDITION	DATE(s)	CONDITION	DATE(s)
Musculoskeletal:		**Blood/Immune System**	
Neck pain		High cholesterol/triglycerides	
Mid back pain		High glucose	
Low back pain		Hypothyroidism	
Head Aches Mild Moderate Severe Daily Weekly Monthly		Diabetes	
		Allergies	
Numbness/Tingling Arm Hands Thighs Leg Foot		Sinus Infections	
		Ear Infections	
Foot/Ankle Pain		**Digestive System:**	
Hip Pain		Acid Reflux/GERD	
Knee Pain		Peptic ulcer *(gastric/duodenal)*	
Elbow Pain		Constipation	
Carpal Tunnel		Irritable bowl syndrome	
Dizziness		Nausea	
Arthritis		Vomiting	
Rheumatoid Arthritis			
Sciatica		**Vasculature:**	
Herniated/Degenerated Disc Condition		Varicose veins	
Fibromyalgia		Blood clots	
Ear Aches		Stroke/TIA	
Abnormal X-Ray or MRI findings		Peripheral Artery Disease (PAD)	
Shoulder Pain		Hardening of the arteries	
Wrist Pain			
Heart:		**Lungs:**	
High blood pressure		Pneumonia	
Heart Attack		Asthma	
Angina		Bronchitis	
Congestive heart failure		COPD	
Nervous system:		Emphysema	
Neuralgia			
Migraines		**Other Conditions:**	
Cluster Headaches		Chest pressure/tightness with exertion	
Pinched nerves		Chest pressure/tightness with rest	
Depression		Generalized weakness	
Panic Attacks/Anxiety		Cancer: Type:	
		Night Sweats	
Organ System:		Trouble breathing	
Kidney Stones		Feeling faint or passing out	
Gallstones		Pain in legs while walking	
Hepatitis		Recent Weight loss: # pounds lost	
Bladder infections		Recent weight gain: # pounds gained	
Enlarged Prostate		Swollen feet or ankles	

List any other problems not mentioned above: _____

Physician reviewed: _____ Date: _____

c. Do you drink alcohol? Yes q No q *(If yes how much?_____how often?_____)*

d. Medications Currently Take:

_____

_____

_____

e. Herbal or Dietary Supplements?

_____

f. Number of meals per day: _____ Number of "fast food" meals per week? _____

g. Exercise Regularly? Yes No
(If yes what activity?_____ how long?_____ how often?_____)

h. Work/Occupation? _____

i. Have you had any work related illness or injuries? Yes No
If yes please explain: *Injury/Illness* *Date*

_____ _____

k. Are there any Hobbies you do or would like to do that are effected by your condition? Yes No
1) Hobby: _____ How much: Mildly Moderately Significantly Cant Do
2) Hobby: _____ How much: Mildly Moderately Significantly Cant Do
3) Hobby: _____ How much: Mildly Moderately Significantly Cant Do

l. Are there any daily activities that you do or need to do that are effected by your condition? Yes No
1) Activity: _____ How much: Mildly Moderately Significantly Cant Do
2) Activity: _____ How much: Mildly Moderately Significantly Cant Do
3) Activity: _____ How much: Mildly Moderately Significantly Cant Do

IV. HEALTH MAINTENANCE

Primary Care Physician: _____

For Males

a. Date of last physical exam: _____
b. Date of last blood tests: _____
c. Date of last prostate check: _____

For Females

a. Date of last physical Exam: _____
b. Date of last blood test: _____
c. Date of last bone density Exam: _____
d. Date of last Breast exam: _____

INFORMED CONSENT TO CHIROPRACTIC SPINAL MANIPULATION, SUPPORTIVE CARE AND CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.
I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.
I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there is some risk to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns.
I understand and comprehend all such risks and complications. I , by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed by my doctor to be in in my best interest.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by doctor staff:

Name and address of clinic/office:

Dr. Nicole Muschett, D.C.
3005 Brodhead Road, Suite 182
Bethlehem, PA 18020

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

_____
Print Patient's Name

_____
Print Name of Patient's Representative
As:
Relationship or Authority of Patient's Rep.

_____
Signature of Patient's Representative

_____
Date Signed
Print name(s) of doctor(s) treating this patient:
Dr. Nicole Muschett, D.C.

Witness to Patient's Signature: _____
Date Signed_____

DR. NICOLE MUSCHETT, D.C.

3005 Brodhead Road
Suite 182
Bethlehem, PA 18020

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made in an alternative means, such as sending correspondence to the individual's Office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____
_____: O.K. to leave message with detailed information
_____: Leave message with call-back number only.

Written Communication
_____:O.K. to mail to my home address
_____: O.K. to mail to my work/office address
_____: O.K. to mail to school/college address

Work Telephone: _____
_____: O.K. to leave message with detailed information
_____: Leave message with call-back number only
_____: Do not call work number

Cell Phone: _____

E-mail: _____

Other: _____

Patient Name: _____

Date of Birth: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP)
This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communications, and
5. The right to a paper copy of this notice

We want to assure you that your medical protected health information is secure with us. This notice contains information about how we will insure that your information remains private.

If you have any questions about this notice, our name and phone number are listed on this page.

Dr. Nicole Muschett, D.C.
3005 Brodhead Road
Suite 182
Bethlehem, PA 18020

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this NOTICE OF THIS PRIVACY PRACTICES. I understand That if I have questions or complaints regarding my privacy rights that I may contact the office listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in anyway"

Patient or representative Name (please print)

Patient or representative signature Date:

Patient refused to sign: Patient was unable to sign because: