South Shore Chiropractic, LLC

DR. GARY MRUZ
DR. WILLIAM MACK III

Patient Intake Form

File Number_____

TODAY'S DATE [, ,]

Full Name: First_____ MI_____ Last_____

Name you preferred to be called:_____ Referred by: _____

Address:_____ City:_____ State:_____ Zip:_____

Age:_____ Birth Date:_____ Gender: ❑ Male ❑ Female

Social Security Number:_____ Email Address:_____

By providing my email address, I authorize my doctor to contact me via the email address provided

Home Phone:_____ Work Phone:_____ Cell/Other:_____

Marital Status *(check one)* ❑ Single ❑ Married ❑Widowed ❑ Divorced

Employment Status *(check one)* ❑ Employed ❑ Student ❑ Retired ❑ Self Employed

Employer:_____ Occupation:_____

Business Address: _____ City:_____ State:_____ Zip:_____

Emergency Contact:_____ **Relation**:_____ **Phone**:_____

Payment Information Person Responsible for Payment: _____ Phone:_____

Insurance Information (It is your responsibility to understand your coverage prior to your appointment)

Primary Insurance	**Secondary Insurance**
Insurance Company:	Insurance Company:
Insured's Name:	Insured's Name:
Relationship to Patient:	Relationship to Patient:
Insured's Date of Birth:	Insured's Date of Birth:
Insured's Employer:	Insured's Employer:

Consent for Treatment

Assignment & Release: *By signing below, I authorize South Shore Chiropractic, LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to South Shore Chiropractic, LLC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance of any tests or procedures needed. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician. If patient is a minor, by signing I give consent for examination, tests, and procedures for the above minor patient.

Signed: _____ Date:_____

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DR. WILLIAM MACK III

South Shore Chiropractic, LLC

Health Questionnaire

Patient Name:_____ **Date:**_____

Medications **Reason for taking**

_____

_____

_____

Allergies: _____

List any surgeries or hospitalizations you have had. Please include month and year for each:

_____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

Family History: List all major diseases such as cancer, diabetes, strokes/TIA's, heart problems, bone/joint diseases, Neurological diseases, and the relation to you of the individual:

_____

Do you exercise? ❑ Yes ❑ No Hours per week: _____ What activity(s): _____

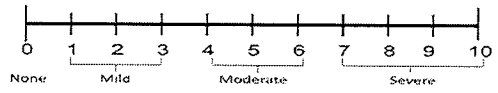
Tobacco use ❑ Smoker ❑ Former smoker ❑ Never been a smoker

For women: Are you pregnant or nursing? ❑ Yes ❑ No If pregnant, how many weeks?_____ Due date:_____

Medical History
Describe the reason(s) for your doctor visit today:

_____

Are you in pain? ❑ Yes ❑ No Rate your pain with the following scale



Did your symptoms occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity

When did your symptoms start?_____ How did your symptoms begin?_____

How often do you experience symptoms? ❑ Constantly ❑ Frequently ❑ Intermittently ❑ Occasionally

Describe your symptoms: ❑ Achy ❑ Burning ❑ Dull ❑ Sharp ❑ Stiff ❑ Throbbing ❑ Spasm ❑ Tingling

Are your symptoms: ❑ Getting better ❑ Staying the same ❑ Getting worse

What makes your symptoms better? ❑ Nothing ❑ Walking ❑ Standing ❑ Sitting ❑ Lying down ❑ Moving ❑ Rest

What makes your symptoms worse? ❑ Nothing ❑ Walking ❑ Standing ❑ Sitting ❑ Lying down ❑ Moving ❑ Rest

SOUTH SHORE CHIROPRACTIC, LLC

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Patient Name :_____ **Date :**_____

How do your symptoms interfere with your work or normal activities?_____

_____

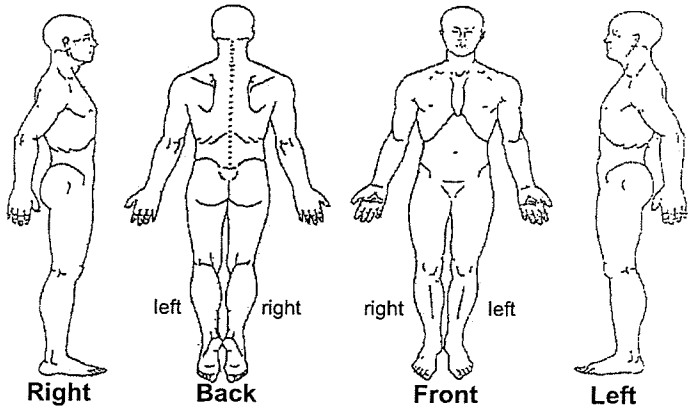
Has this or something similar happened in the past? ❑ Yes ❑ No Explain

_____

History of Treatment
Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No If so, where?_____

_____

Have you ever been treated by a Chiropractor? Clinic or Doctor's Name_____



Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A= Ache **B**=Burning **N**=Numbness
P=Pins & Needles **S**=Stabbing **O**=Other

Foot Orthotics Gait

Height: Feet _____ inches_____ Weight: _____pounds Shoe Size:_____ Wide/Regular

Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive/Irregular Menstruation
- ☐ Eye Pain of Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Sleep problems of Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Other:_____

(Neck/Shoulders/Upper)

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

(Neck / Shoulders / Upper)

(Back / Hips / Lower)

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

(Back / Hips / Lower)

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Patient Name:_____ **Date:**_____

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, by are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name