



PATIENT INFORMATION

Welcome! Please complete all questions.

Name:		Date:	
Address:		City/State/Zip:	
Home Phone:		Work/ Cell Phone:	
Birth Date:		Age:	Social Security #:
Marital Status:		M	W
		D	S
		Spouse's Name:	
Your Employer:		Occupation:	
Children's Names and Ages:			
Favorite Hobbies or Interests:			
Method of Payment for First Visit: Cash Check Credit Card CareCredit			
E-mail Address:			

Reasons For Consulting Scranton Clinic of Chiropractic:

1. _____
2. _____
3. _____
4. _____

Who may we thank for referring you? _____

What is the name of your primary medical doctor? _____

Other doctors seen for this condition _____

Would it be okay for us to contact them just to let them know that you have come to us for this problem and that this is the care we are providing. This way we can make sure that you are getting the best care from your chiropractor and your medical doctor? (Please initial here) _____

Your Nervous System is susceptible to interference from the first day it is formed. After conception, the Nervous System is the first structure formed in the fetus. It's responsibility is to coordinate and direct the formation of an entire human being. Your growth in the womb and your birth experience are critical to the rest of your development, because they are events which can be traumatic to the Nervous System decreasing ones life and health potential at the start of their life.

Please circle the best response

- | | | | |
|-----|----|--------|---|
| Yes | No | Unsure | 1. Pregnancy – While your mother was pregnant with you did she...? |
| Yes | No | Unsure | smoke or drink alcohol? |
| Yes | No | Unsure | have a proper diet? |
| Yes | No | Unsure | exercise through her pregnancy? |
| Yes | No | Unsure | experience any falls and injuries during pregnancy? |
| Yes | No | Unsure | experience any physical and/or mental abuse? |
| Yes | No | Unsure | have any illnesses during pregnancy? |
| Yes | No | Unsure | take any prescription medication/OTC medication during pregnancy? |
| Yes | No | Unsure | have regular Nervous System/Chiropractic Check ups during pregnancy? |
| | | | |
| Yes | No | Unsure | 2. Birth Process - When you were born...? |
| Yes | No | Unsure | Was the delivery long? |
| Yes | No | Unsure | Was the delivery difficult? |
| Yes | No | Unsure | Forceps or extraction devices used? |
| Yes | No | Unsure | Caesarean? |
| Yes | No | Unsure | Breach or Cephalic? |
| Yes | No | Unsure | Home Birth? |
| Yes | No | Unsure | Hospital Birth? |
| Yes | No | Unsure | Mother given drugs during delivery? |
| Yes | No | Unsure | Was labor induced? |
| Yes | No | Unsure | Were you checked by a Chiropractor for Nervous System Interference? |
| | | | |
| Yes | No | Unsure | 3. Growth & Development - While you were growing up...? |
| Yes | No | Unsure | Did you have regular spinal check-ups for Nervous System Interference? |
| Yes | No | Unsure | Were you breast fed? How Long? _____ |
| Yes | No | Unsure | Childhood sicknesses? _____ |
| Yes | No | Unsure | Accidents? _____ |
| Yes | No | Unsure | Surgery? _____ |
| Yes | No | Unsure | Drugs? _____ |
| Yes | No | Unsure | Did you fall while learning to walk? |
| Yes | No | Unsure | Did you rough house with siblings or friends? |
| Yes | No | Unsure | Child Abuse? |
| Yes | No | Unsure | Spanking / Pulling on ear, chin, arms or legs etc.. |
| Yes | No | Unsure | Other traumas? _____ |

As we continue life we still encounter stress that can impact our Nervous System and cause interference. Lifestyle choices affect your level of Nervous System Interference. Nervous System Interference is caused by the three T's, *thoughts, traumas, toxins*.

Yes	No	Unsure	Did/Do you smoke? How Much / How Long? _____
Yes	No	Unsure	Did/Do you drink alcohol? _____
Yes	No	Unsure	Do you eat healthy foods? _____
Yes	No	Unsure	Have you been in accidents? _____
Yes	No	Unsure	Have you had surgery? Organs removed / replaced? _____
Yes	No	Unsure	Drugs? Prescription / Non-prescription? _____
Yes	No	Unsure	Exercise regularly? Activity _____ Days per week _____
Yes	No	Unsure	Did/Do you have occupational success? _____
Yes	No	Unsure	Physical Stress? _____
Yes	No	Unsure	Mental Stress? _____
Yes	No	Unsure	Any other traumas or problems? _____
Side	Back	Stomach	Sleeping Posture? _____

When an individual begins life with limited health and life expression as a result of Nervous System Interference, and continues to encounter thoughts, traumas, and toxins. After the body's function has been decreased for long periods of time the body is unable to run at it's best and is unable to carry out it's responsibility of running all body functions. Eventually the body has to tell us about the injustice we are doing to it and talks to us through symptoms. The symptoms are collectively named by doctors as a

Why did you consult this office? _____

How does that affect your daily activities? _____

Does it affect your family? _____

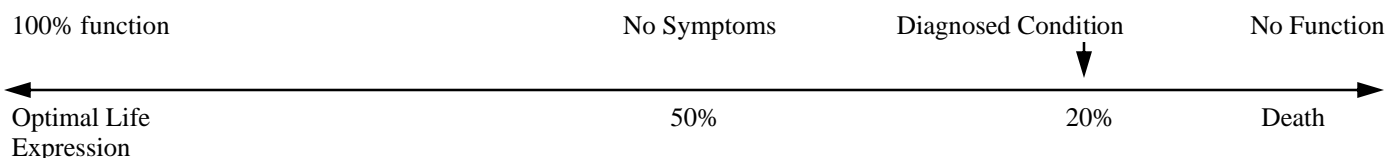
How has having this complaint changed your life? _____

How does having this complaint make you feel? _____

Do you have any other concerns? _____

Please mark the wellness scale below by putting a circle where you feel you are currently and a star with where you want to be in the future.

Wellness Scale



The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

Terms of Acceptance

4.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well- being, not merely the absence of disease and infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding, treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
Print name

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on the basis.

Signature

Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform and x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

Signature

Date

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Scranton Clinic of Chiropractic/ Smith Chiropractic

Notice Of Privacy Practices

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 28, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Sign-In Log: The office maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's in the office suite. This information may be seen by, and is accessible to, others who are seeking care in this office.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, \$20.00 per hour (with a minimum of \$20.00) for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. Contact Officer: Dr. Robert Scranton. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Scranton Clinic of Chiropractic/ Smith Chiropractic

Dr. Robert Scranton, DC and Dr. Willard Smith, DC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

