Papalia Family Chiropractic

Dr. Pasquale F. Papalia
1811 King Road • Trenton, MI 48183
(734) 692-7884 • Fax (734) 675-2813 • *"Chiropractic, It's a Natural"*

PATIENT INFORMATION

Date: _____

Name (last name first)			Date of birth	Age	Social Security No.
Address	City	State	Zip		Telephone no.
☐ Male ☐ Female	☐ Single ☐ Married	Name of Spouse	Health status		Cell phone no.
No. of children	Names of children		Health status		Email:
Occupation	Employer		Work phone no.		
In case of emergency please contact - Name:			Telephone no.		
Briefly describe your problem: 1.			Doctors seen for these problems (give names) 1.		
2.			2.		
3.			3.		
4.			4.		
Treatment given for these problems (Examples: medicine, surgery, physical therapy)					
Referred by	Have you had chiropractic care before? ☐ Yes Where? ☐ No		Name of health insurance co.?		
Is it possible you are pregnant? ☐ Yes ☐ No	Are you on Medicare? ☐ Yes ☐ No	Are you on Medicaid? ☐ Yes ☐ No	Are you on a reimbursing insurance policy? ☐ Yes ☐ No Company Name:		
Please indicate if you are here for care because of:	☐ an on the job injury	☐ an auto accident			
Date injured	Insurance company	Attorney's name	Attorney's address		

Have you ever had any falls, accidents or injuries? ☐ Yes Please describe. ☐ No	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY

Have you ever had surgery? ☐ Yes Please describe. ☐ No	MONTH, YEAR	TYPE OF SURGERY	WHY WAS SURGERY PERFORMED?

Are you presently taking medication? ☐ Yes ☐ No Please list the name of the drug and tell why you are taking it.	NAME OF DRUG	DOSES PER DAY	WHAT ARE YOU TAKING IT FOR?

PLEASE SEE OTHER SIDE

ATTN PATIENTS: PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD A PROBLEM WITH:

- ☐ Headaches
- ☐ Shooting head pain
- ☐ Head feels too heavy
- ☐ Twitching of face
- ☐ Sinus Trouble
- ☐ Dizziness
- ☐ Pain in ears ☐L ☐R
- ☐ Ringing in ears ☐L ☐R
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Neck pain
- ☐ Stiff neck
- ☐ Grating in neck
- ☐ Muscle spasms in neck
- ☐ Thyroid trouble
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Tightness of throat
- ☐ Difficulty breathing
- ☐ Chest pain
- ☐ Mid Back pain
- ☐ Shoulder pain ☐L ☐R
- ☐ Tightness in shoulders ☐L ☐R
- ☐ Arm pain ☐L ☐R
- ☐ Numbness in arms ☐L ☐R
- ☐ Elbow pain ☐L ☐R
- ☐ Wrist pain ☐L ☐R
- ☐ Cold hands ☐L ☐R
- ☐ Tingling in hands ☐L ☐R
- ☐ Numbness in hands ☐L ☐R
- ☐ Pain in side ☐L ☐R
- ☐ Rib pain ☐L ☐R
- ☐ Hip pain ☐L ☐R
- ☐ Low Back pain
- ☐ Pain in legs & feet ☐L ☐R
- ☐ Numbness in legs ☐L ☐R
- ☐ Cramps in legs ☐L ☐R
- ☐ Poor Circulation
- ☐ Sciatica ☐L ☐R
- ☐ Knee pain ☐L ☐R
- ☐ Ankle pain ☐L ☐R
- ☐ Nervousness
- ☐ Scoliosis
- ☐ Fatigue
- ☐ Irritability
- ☐ Sleeping trouble
- ☐ Arthritis
- ☐ Bursitis
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Ulcers
- ☐ Stomach pain
- ☐ Indigestion
- ☐ Constipation
- ☐ Colitis
- ☐ Urinary trouble
- ☐ Kidney trouble
- ☐ Liver trouble
- ☐ Menstrual cramps
- ☐ Menstrual irregularity
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Others: Please Describe _____

SPECIAL INSTRUCTIONS

DO NOT WRITE BELOW THIS LINE

	Subluxation	Corrective Tissue	Nerve Tissue	Bio Mechanical	Symptoms
1°					
2°					
3°					
4°					

SECONDARY COMPLAINTS - Doctors use only

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Dorsolumbar Range of Motion	PAIN +	PAIN −	RESULT	NORM
Flexion				45
Extension				35
Lateral Flexion				40R
Lateral Flexion				40L
Rotation				35R
Rotation				35L

Cervical Range of Motion	PAIN +	PAIN −	RESULT	NORM
Flexion				45
Extension				50
Lateral Flexion				40R
Lateral Flexion				40L
Rotation				55R
Rotation				55L

SUBJECTIVE FINDINGS -

PAIN CLASSIFICATION	C	T	L
Minor	☐	☐	☐
Moderate	☐	☐	☐
Severe	☐	☐	☐

N F R

OBJECTIVE FINDINGS -

	Cervical L	Cervical R	Thoracic L	Thoracic R	Lumbar L	Lumbar R
☐ Muscle spasms	☐	☐	☐	☐	☐	☐
☐ Fixations	☐		☐		☐	

Areas of Tenderness	L	R
Cervical		
Dorsal		
Lumbar		
Pelvic		

	L	R
Head tilt		
Shoulder high on		
Ilium high on		

ORTHOPEDIC TESTS

	L	R	B	N
☐ Anvil	☐	☐	☐	☐
☐ Lindner's	☐	☐	☐	☐
☐ Foraminal Compression	☐	☐	☐	☐
☐ Shoulder Depression	☐	☐	☐	☐
☐ Soto-Hall	☐	☐	☐	☐
☐ Kemp's	☐	☐	☐	☐
☐ Braggard's	☐	☐	☐	☐
☐ Fabre Patrick's	☐	☐	☐	☐
☐ Lasegue's ☐L___° ☐R___°	☐	☐	☐	☐

Height _____ Ambulatory ☐Yes ☐No

Weight _____ Analgia ☐L ☐R ☐None

Doctor _____

CORRECTIVE CARE PLAN

- ☐ Daily visits for _____ weeks
- ☐ 3 visits for _____ weeks
- ☐ 2 visits for _____ weeks
- ☐ 1 visit for _____ weeks
- ☐ 1 visit every 2 weeks
- ☐ 1 visit per month

Date _____ M T W Th F Sa Su

X-RAY REPORT & SPINAL ANALYSIS

At	☐	1L	☐
Ax	☐	2	☐
3	☐	3	☐
4	☐	4	☐
5	☐	5	☐
6	☐		
7	☐		
1D	☐	**L. Ilium**	
2	☐	☐	PI
3	☐	☐	As
4	☐	☐	In
5	☐	☐	Ex
6	☐		
7	☐	**R. Ilium**	
8	☐	☐	PI
9	☐	☐	As
10	☐	☐	In
11	☐	☐	Ex
12	☐		

Osteophytic Changes

C	T	L
☐	☐	☐

Degeneration

C	T	L
☐	☐	☐

Loss of Lordotic Curve

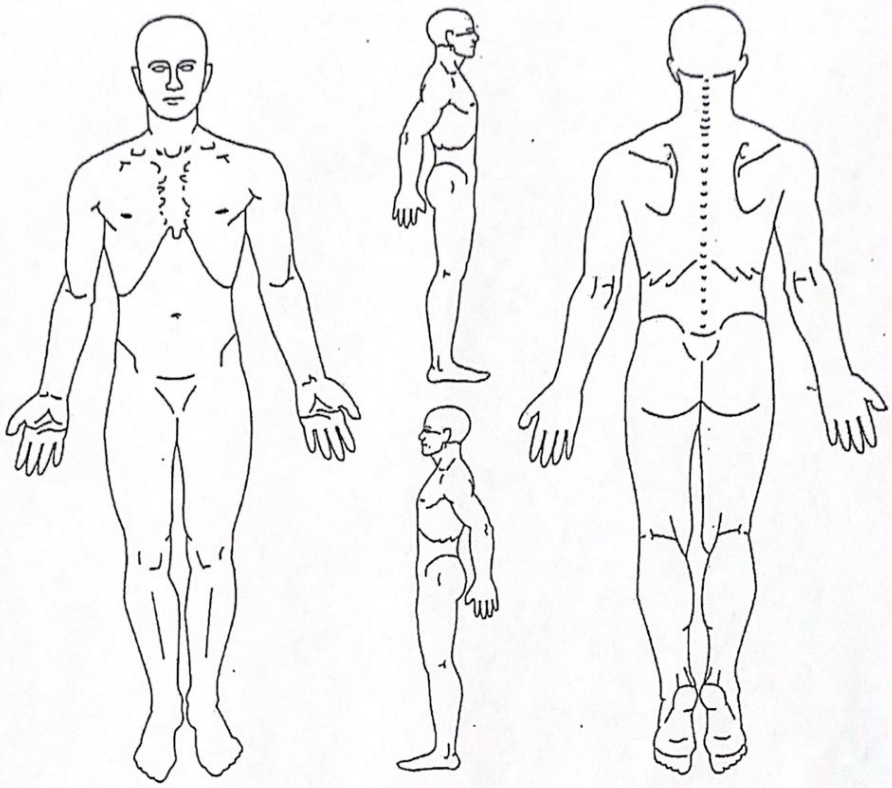
C	L
☐	☐

Other: _____

Patient Name: (print) _____ Date: _____

Please draw the location of you pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D= Dull	B= Burning	N= Numb	S= Stabbing/Cutting	T= Tingling (Pins & Needles)	C= Cramping



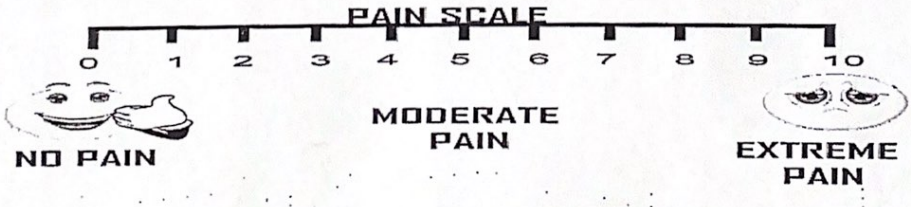
On the scales below, please indicate your number of pain or discomfort:

Rate the pain you have right now: _____

Rate your pain at its best in the past week: _____

Rate your average pain in the past week: _____

Rate your worst pain in the past week: _____



Hippa 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 Practices describes how we may use and disclose your protected health information. (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, 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, to pay your health care bills, to support the operation 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 protected health 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 medical test may require that your relevant protected health information be disclosed to the health plan to obtain approval for the medical test.

Healthcare operations

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting 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 sheets registration desk where you will be asked to sign your name. 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 include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation Research; Criminal Activity; Military Activity; National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the Law. We are required to make disclosures to you and 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 physicians practice had taken an action in reliance on the use or disclosure indication in the authorization.

...is a statement of your rights with respect to your protected health information.

You have the right to review and receive a copy of your protected health information (following office procedures and copy fees). Under federal law, however, you may not inspect of copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or us in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family member or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If physicians believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternatives means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice. Before we make an important change in our privacy practices, we will both post the new notice and make it available upon request. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

**This notice was published and becomes effective on/or before April 14th, 2003 and was updated January 1st, 2006. **

Disclosure of Protected Health Information

I give my consent to disclose my lab/test results, patient notes, account balances, medication requests and telephone inquiries regarding any and all treatment relating to myself.

Persons to Whom Information May Be Disclosed:

Name _____ Relationship_____ Date of Birth _____

Name _____ Relationship_____ Date of Birth _____

We are required by law to maintain the privacy of, and proved individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is an acknowledgement that you have received this Notice of our Privacy Practices and have had the opportunity to identify those person(s) whom which you have given permission to disclose information.

Name: _____ Signature: _____ Date: _____

Papalia Family Chiropractic
Dr. Pasquale F. Papalia
Chiropractor
1811 King Rd.
Trenton, MI 48183
(734) 692-7884
'Chiropractic, it's a Natural"

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and herby release this clinic of any consequence thereof.

FINANCIAL RESPONSIBILTY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayment and any services rejected by my insurance company.

INSURANCE BENEFITS

I understand that "verification" of my chiropractic benefits under my insurance plan is my responsibility. I understand that Dr. Papalia's office will call my insurance carrier to obtain benefit information, but I understand that what they are told is not necessarily accurate information and that ultimately it is up to me to call myself to obtain and verify benefits.

_____ _____

Patient Signature Date

Patient Name _____ Date _____

Describe your symptoms:

_____

_____

_____

(a)When did your symptoms start? _____

(b)How did your symptoms begin? _____

How often do you experience your symptoms?

(1) Constantly (76-100% of the day) (2) Frequently (51-75% of the day)

(3) Occasionally (26-50% of the day) (4) intermittently (0-25% of the day)

How are your symptoms changing?

(1)Getting Better (2) Not Changing (3) Getting Worse

During the past 4 weeks:

(a)Indicate the average intensity of your symptoms 1 thru 10 and 10 being the worse _____

(b)How much has pain interfered with your normal work (including both work outside the home and housework)

(1.) Not at all (2.) A little bit (3.) Moderately (4.) Quite a bit (5.) Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities?

(Visiting with friends, relatives. ECT.)

(1)All of the time (2) Most of the Time (3) some of the time (4) A little of the time (5) none of the time

In general would you say your overall health right now is...?

(1)Excellent (2) Very Good (3) Good (4) Fair (5) Poor

Who have you seen for your symptoms?

(1) No One (2) Other Chiropractic (3) Medical Doctor (4) Physical Therapist (5) Other

a. What treatment did you receive and when? _____
b. What tests have you had for your symptoms and when were they performed?
(1) X-rays/date: _____ (2) CT Scan/date: _____ (3) MRI/date: _____ (4) Other/date: _____

Have you had similar symptoms in the past? (1) Yes (2) No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
(1) This Office (2) Other Chiropractic (3) Medical Doctor (4) Physical Therapist (5) Other

What is your occupation? _____
What is your current work Status? Full time/Part Time/Self Employed/Off Work/Unemployed

Patient Signature_____ Date _____

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practiced staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patients Name Printed Date

_____ _____

Patients Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.