Welcome to Great Works Chiropractic

Home of the 3B Synergy Health Systems

Hey there, we are so excited to welcome you to our office! Your intake appointment with Dr. Seth has officially been scheduled and the next step in your care in completing our comprehensive but vital intake paperwork.

Attached you can find your intake paperwork to complete before your exam. While filling it out please follow the following instructions.

–Please *fill out paperwork completely*, do not leave anything blank or unfinished.

–Please use either a black or blue pen.

–If you have questions about any portion of the paperwork, or do not have the time to complete it prior to your exam, please arrive at your appointment ten to fifteen minutes early to receive help from the front desk.

-Please do not print your paperwork out double-sided. Print it out one sheet per page.

On the day of your appointment we ask that you please arrive on time and bring the following items with you;

- Insurance card(s)
- Loose comfortable clothing - ***please wear short sleeves if possible***.
- Your completed intake paperwork.

We cannot wait to meet you and start working with you. You have just taken a great step in getting your life back and we can't wait to watch all the progress you are going to make. If you have any questions please do not hesitate to call the office at (207) 704-0298

Great Works Chiropractic Patient Introduction

Name: ____Birthdate: ______ /______ /______ Sex: ___M ___F

Mailing Address:____

Phone: (C) ________________________ (H) ________________________ (W) ________________________

What number is preferred? ____________ E – Mail: ____

How would you like to be reminded of appointments? ___E – Mail ___Text Message

Please circle your Marital Status: Married Widowed Single Separated Divorced Partnered

Spouse's Name: ____

Children and Ages:____

Occupation:_______________________________________ Employer:________________________________

Hobbies / Interests:____

Present Primary Care Physician:________________________Practice/Location:_________________________

How did you hear about us?____

Responsible Party:

Name of person responsible for this account:____

Relationship to patient: ___________________________Phone (________) ________-__________

Address: ____ City: _________________________

State: ______________________ Zip: ___________

Insurance Information: ***Please present all insurance cards to front desk. Thank you.***

Certification and Assignment: To the best of my knowledge, all provided information is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health.

I certify that I, and / or my dependents are insured with _________________________________.

And assign directly to Great Works Chiropractic & Wellness P.A. all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance.

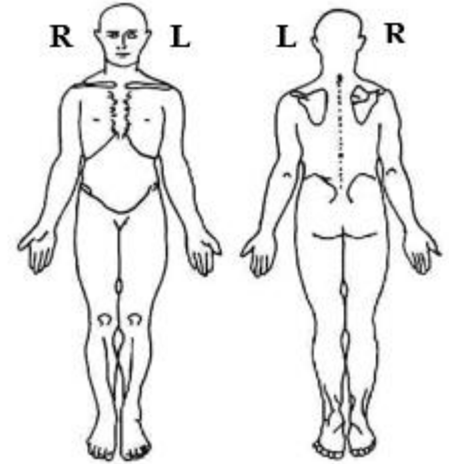
I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient or Representative: _______________________________ Relationship: ______________

Printed name of Patient:____________________________________ Date: __________________________

Great Works Chiropractic Adult Health History

Name: ____ Date: ______________



Chief Complaint: Main Reason for Today's Visit: _____________________

____

____

(Please mark area on diagram to the right, use arrows to indicate if the pain travels)

Please rate pain level – when at its ***worst*** with an "x" on the line below:
:

Is this associated with an accident or injury? Yes___ No___

If yes, please explain:

____

How often do you feel it?: ☐ Constant ☐ Intermittent ☐ Only associated with_______________________

Please indicate the quality of the pain: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Stabbing

☐ Burning ☐ Shock-like ☐ Other (describe):____

How did it start? ____

How long have you suffered with this problem? ____

What aggravates your symptoms? ____

What have you tried to help this that DID NOT work? ____

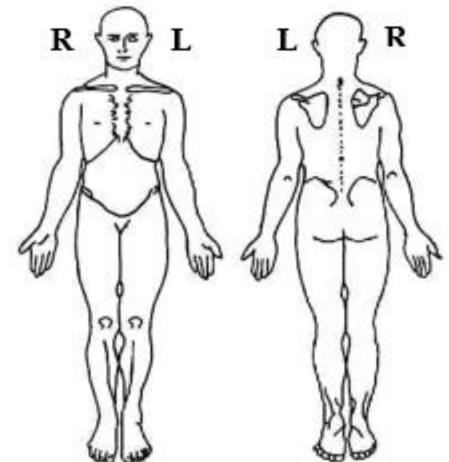
What have you tried that gives you some temporary relief? _____________________________________

Have you experienced this issue in the past? ____

Who else have you seen in the past for this complaint? ____

____

Secondary Complaints: Any additional complaints?
(Please list below and mark on the diagram to the right)



1:___________________ **2**:____________________**3**:_____________________

Rate severity of each complaint with its number ("#1," etc.) on line below:

Family and Social History: Do you or anyone in your immediate family have a history of cancer, heart disease or diabetes? ***(Please indicate whom, and if cancer what type):*** ____

____

Any Diagnoses/Conditions not listed: ____

Activities of Daily Living: Which specific activities are adversely affected because of your problems?

☐ Sitting	☐ Rising out of chair	☐ Standing	☐ Walking
☐ Lying down	☐ Bending over	☐ Climbing Stairs	☐ Using a computer
☐ Getting in/out of car	☐ Driving	☐ Looking over shoulder	☐ Caring for family
☐ Grocery shopping	☐ Chores	☐ Lifting objects	☐ Reaching overhead
☐ Showering/bathing	☐ Dressing myself	☐ Love life	☐ Getting to sleep
☐ Staying asleep	☐ Concentrating	☐ Exercising	☐ Yard work

Systems Review: Due to the complex neurological connections that govern the body's physiology, bodily pain is often associated with other problems. Please mark all that you have now or have ever had (even if managed by medication) to help us better understand your case. Use "C" for current problem, "P" for past, "M" for medicated.

☐ ADHD	☐ Allergies	☐ Arthritis	☐ Asthma	☐ Back Trouble
☐ Bed Wetting	☐ Insomnia	☐ Chest Pain	☐ Colic	☐ Constipation
☐ Crohn's Disease	☐ Depression	☐ Diarrhea	☐ Disc Problems	☐ Ear Infection
☐ Emotional Issues	☐ Epilepsy	☐ GERD/Reflux	☐ Headaches	☐ Heartburn
☐ High Blood Press.	☐ IBS	☐ Indigestion	☐ Infertility	☐ Motion Sickness
☐ Low immunity	☐ Low energy	☐ Migraines	☐ Arm/Hand Pain	☐ Leg/Foot Pain
☐ Neck Trouble	☐ Vertigo	☐ Anxiety	☐ PMS/irregularity	☐ Menstrual Pain
☐ Pinched Nerve	☐ Scoliosis	☐ Sinus Trouble	☐ Numbness/Tingling Arms/Hands	
☐ Poor balance	☐ Poor posture	☐ TMJ Problems	☐ Facial Pain/Numbness/Tingling	
☐ Breathing issues	☐ Sleeping problems	☐ Poor circulation	☐ Numbness/Tingling Legs/Feet	

Any Diagnoses/Conditions not listed: ____

____

****Please note***: many conditions such as high blood pressure, reflux, IBS, mood/mental focus disorders and many others of the above named conditions often improve while under NeuroStructural Corrective Care in this office. Many patients choose to discontinue medications as a results of this because prescriptions often cause a myriad of problems in their own right. Please, you *must* consult your prescribing doctor if your experience any of these improvements *before* discontinuing any medications. This office cannot advise you on these matters.

What medications, if any (OTC or Rx), are you currently taking? (Please list all): _________________________

____

Surgeries: Please list all (left or right side if applicable) and approximate date: ____________________________

____

Quality of Life: How does your problem interfere with the following areas of your life?:

Work: ______________________________

Family: ______________________________

Hobbies: ______________________________

Quality of Life: ______________________________

Do you smoke? ☐Y ☐N If yes, how much? ______________________________

Do you drink alcohol? ☐Y ☐N If yes, how much and how often? ______________________________

Past History: Physical, emotional and chemical strain play a large part of a person's health picture and can have lasting effects on neurological function and structural integrity. Please check if you have or have had difficulties with any of the following:

☐ Difficult birth or delivery	☐ Auto accidents	☐ Sports injuries	☐ Falls
☐ Bad Posture	☐ Eating junk food	☐ Repetitive motion	☐ Emotional tension
☐ Pushing yourself too hard	☐ Being a couch potato	☐ Dental work	☐ Surgery
☐ Awkward work positions	☐ Mild jar when unprepared	☐ An emotional shock	☐ Long car rides
☐ Childhood accidents	☐ Being on medication	☐ Using the same body position over and over at work or play (repetitive strain injury)	

Comments/details: ______________________________

____

Developmental History: Most of our adult patients' problems get their start in childhood, which they seem to "grow out of" only to "grow into" its adult manifestation. Please indicate if you ever had any of the following signs of pediatric spinal distress:

☐ Ear infections	☐ Car sickness	☐ Developmental delays	☐ Acid Reflux
☐ Colic	☐ Bed Wetting	☐ Failure to thrive	☐"Sickly" childhood
☐ Asthma	☐ Learning Disorders	☐"Growing Pains"	☐ Poor Posture
☐ Constipation	☐ Delayed/late to walk	☐ Mental focus problems	☐ Other aches/pains

Comments/details: ______________________________

____

****Please note:*** the above are signs of Pediatric Spinal Distress. Our doctors are both extensively trained via the International Chiropractic Pediatric Association (ICPA) to care for infants and children, and are fully equipped to do so. Ask about our affordable family programs.

249 Main Street South Berwick, ME 03908
*(P) 207-704-0298 * (F) 207-704-0389*

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Great Works Chiropractic & Wellness (GWCW) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to GWCW to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If GWCW contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to GWCW to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media. I also give them permission to use my image (photographs or videos) for marketing reasons on their website or in office.
- I give GWCW permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving GWCW permission to use and disclose your protected health information in accordance with the directives listed above.
- I give GWCW permission to send records to my Primary Care Provider or others who may have treated me for a similar condition in order to better my care.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Great Works Chiropractic & Wellness plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

(over)

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of GWCW. The written notice must contain the following information:
Your name, and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.
The revocation is not effective until it is received by the Privacy Official.
This AUTHORIZATION is requested by GWCW for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*
I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, GWCW will not refuse to provide treatment however, it will not be possible for GWCW to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since GWCW will be unable to contact me 3) all contact with GWCW regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*
I have the right to inspect or copy, within legal boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's name (please print): ____

Patient's Signature: ____

Today's Date: _______________________________ DOB: _________

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative Name (please print):

____

Signature: ____

Description of Representative's Authority to Act on Patient's Behalf: __________________________

GREAT WORKS CHIROPRACTIC

Consent for Radiology

I, ________________________________, give the doctors of Great Works Chiropractic and Wellness Center my consent to take any and all x-rays needed to better understand my Condition. I have been fully informed of the possible risks and safety standards of this Office.

I also give my consent for films of my child (children) for the same reasons, if applicable.

Patient Signature: _______________________________________ Date: ____________

For People Who Can Become Pregnant Only:

To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.

Patient Signature: _______________________________________ Date: ____________