THE CONCUSSION PLACE

Health History Form

TODAY'S DATE:

PATIENT INFORMATION

Last Name: **First Name:** **MI:** **Birth Date:**

Birth Date: Age: Gender: ☐ M ☐ F | Height: Weight: SSN:

Home Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Primary Email Address:

How did you hear or learn about our office and services?

LEGAL GUARDIAN / GUARANTOR INFORMATION (skip this section if you are the patient)

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other:

Last Name: **First Name:** **MI:** **Nickname:**

Home Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

COMMUNICATION PREFERENCES

How would you like to receive Appointment Reminders?

☐ Email ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ I do not want appointment reminders

Communication with Family Members

☐ Please feel free to leave messages with family members ☐ Do not communicate with anyone other than me

SOCIAL HISTORY

Support System: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Separated ☐ Widowed

Living Arrangement: ☐ Home Alone ☐ Home w/Others ☐ Assisted Living Center ☐ Adult Foster Home ☐ Homeless

How many children are at home with you? Ages of Children:

Amount of help needed at home: ☐ None ☐ Part of the day ☐ Daytime only ☐ Nighttime only ☐ 24 hours a day

Home Accessibility: ☐ # of stairs/steps ☐ Ramp ☐ Walk-in shower ☐ Tub/shower combo ☐ Hand rails

Assistive Devices/Equipment:

☐ Cane	☐ Bath bench	☐ Resting splints	☐ Walker	☐ Brace
☐ Raised toilet seat	☐ Commode	☐ Prosthesis	☐ Wheelchair/scooter	☐ Grab bars
☐ Hospital bed	☐ Dressing equipment	☐ Hearing aids	☐ Glasses/contacts	☐ Lifeline

WORK HISTORY

Occupation:

Employment Status: ☐ Full time ☐ Part time ☐ Active Duty Military ☐ Unemployed ☐ Volunteer ☐ Retired
☐ Full duty ☐ Light duty ☐ Modified duty ☐ Temporary disability ☐ Permanent disability ☐ Applied for disability

Describe your job duties & work environment:

EMERGENCY CONTACT INFORMATION

Last Name: **First Name:** **MI:** **Nickname:**

Home Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

EMERGENCY CONTACT NOT LIVING WITH YOU

Last Name: **First Name:** **MI:** **Nickname:**

Home Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

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IN A SENTENCE OR TWO, WHY ARE YOU HERE TO SEE US?

HOW HAVE THESE ISSUES AFFECTED YOUR LIFE?
PHYSICALLY:
COGNITIVELY:
RELATIONSHIPS/COMMUNICATION:
PERSONAL/SOCIAL/SPIRITUAL LIFE:
WORK/PERFORMANCE:
HOME/FAMILY:

CURRENT MEDICATIONS CLASSES (PRESCRIPTION OR OVER-THE-COUNTER) *please list drug name if checked*		
☐ Pain:	☐ Heart:	☐ Thyroid:
☐ Muscle Relaxant:	☐ Hormones:	☐ Cholesterol:
☐ Anti-inflammatory:	☐ Diabetes:	☐ Bladder:
☐ Anti-nausea:	☐ Respiratory:	☐ Multiple Sclerosis:
☐ Anti-psychotic:	☐ Reflux:	☐ Other:
☐ Antibiotic:	☐ Seizure:	☐ Other:
☐ Allergy:	☐ Blood thinner:	☐ Other:
☐ Blood Pressure:	☐ Cholesterol:	☐ Other:

CURRENT VITAMINS, HERBS, MINERALS, & HOMEOPATHICS		
☐ Omega-3 Fatty Acids (Fish Oil)	☐ Vitamin D	☐ Multiple Vitamin
☐ ProArginine	☐ Protandim	☐ Protein Supplement:
☐ Coconut Oil	☐ Gelatin	☐ Anti-Oxidants
☐ Other:	☐ Other:	☐ Other:
☐ Other:	☐ Other:	☐ Other:

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GENERAL HEALTH AND DIETARY PATTERNS	
How often do you eat food that was prepared at home?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
How often do you smoke?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
How often do you drink LESS than 4 alcoholic beverages per week?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you use alcohol other than socially?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you normally pay attention to information on healthy diet?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you regularly exercise to the point of an increased heart rate?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you snack between meals?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you drink water frequently throughout the day?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you think that protein is a large part of your diet?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you think that veggies is a large part of your diet?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you eat products that contain soy?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you eat products that contain dairy (cow's milk)?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you eat products that contain gluten (wheat, barley or rye)?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Which physical category do you think you best fit?	☐ Underweight ☐ Healthy weight ☐ Overweight ☐ Obese
Have you ever done a gluten elimination diet?	☐ No ☐ Yes
Have you ever done a dairy elimination diet?	☐ No ☐ Yes
Have you ever done a cleanse or detox diet?	☐ No ☐ Yes
Have you ever been tested for food sensitivities?	☐ No ☐ Yes If so, when?
Other comments on diet or nutrition?:	

SLEEP PATTERNS	
Do you take prescription or over-the-counter sleep aids?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you use alcohol to help with sleep?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Is it hard for you to fall asleep?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you frequently wake in the night or early morning?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
If you wake, is it difficult to return to sleep?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you drink fluids if you wake?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you eat food if you wake?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Do you eat just before your bed time?	☐ Never ☐ Almost never ☐ Almost Always ☐ Always
Other comments on sleep?:	

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SYSTEMS CHECK (*please check if you have experienced any of the following)*	
Constitutional (general) Review	
Have you experienced a general decline in health?	☐ No ☐ Yes ☐ New in past 3 months
Have you experienced a general decline in strength?	☐ No ☐ Yes ☐ New in past 3 months
Have you experienced a general decline in endurance?	☐ No ☐ Yes ☐ New in past 3 months
Are you experiencing unusual amounts of fatigue?	☐ No ☐ Yes ☐ New in past 3 months
Are you having trouble performing your daily activities?	☐ No ☐ Yes ☐ New in past 3 months
Do you have a history or any type of cancer?	☐ No ☐ Yes ☐ New in past 3 months
Have you ever been hospitalized? ☐ No ☐ Yes Why/when:	
Have you ever had major surgery? ☐ No ☐ Yes Why/when:	
Head Review	
Have you ever had a concussion or traumatic brain injury?	☐ No ☐ Yes ☐ New in past 3 months
Headaches	☐ No ☐ Yes ☐ New in past 3 months
Migraines	☐ No ☐ Yes ☐ New in past 3 months
Head pain	☐ No ☐ Yes ☐ New in past 3 months
Head pressure	☐ No ☐ Yes ☐ New in past 3 months
Diagnosed masses in your head	☐ No ☐ Yes ☐ New in past 3 months
Cardiovascular (heart & vessels) Review	
Do you have a history of heart attack, heart disease, or have a neck or chest shunt?	☐ No ☐ Yes ☐ New in past 3 months
Pain in or around your heart	☐ No ☐ Yes ☐ New in past 3 months
Palpitations or irregular heart beat	☐ No ☐ Yes ☐ New in past 3 months
Passing out	☐ No ☐ Yes ☐ New in past 3 months
Difficulty breathing with activities	☐ No ☐ Yes ☐ New in past 3 months
Difficulty breathing when lying down	☐ No ☐ Yes ☐ New in past 3 months
Severe attacks of shortness of breath and coughing at night	☐ No ☐ Yes ☐ New in past 3 months
Swelling in legs or arms	☐ No ☐ Yes ☐ New in past 3 months
Blue, cold skin	☐ No ☐ Yes ☐ New in past 3 months
High blood pressure	☐ No ☐ Yes ☐ New in past 3 months
Low blood pressure	☐ No ☐ Yes ☐ New in past 3 months
Heart murmurs	☐ No ☐ Yes ☐ New in past 3 months
Varicose veins	☐ No ☐ Yes ☐ New in past 3 months
Pain in lower legs with walking	☐ No ☐ Yes ☐ New in past 3 months
Have you ever been told you have a blood, vascular or healing disorder?	☐ No ☐ Yes ☐ New in past 3 months
Respiratory (lungs) Review	
Coughing, wheezing, or spitting up blood	☐ No ☐ Yes ☐ New in past 3 months
Shortness of breath or exercise intolerance	☐ No ☐ Yes ☐ New in past 3 months
Gastrointestinal (stomach & gut) Review	
Yellowing of eyes	☐ No ☐ Yes ☐ New in past 3 months
Hemorrhoids	☐ No ☐ Yes ☐ New in past 3 months
Vomiting blood	☐ No ☐ Yes ☐ New in past 3 months
Increase in appetite	☐ No ☐ Yes ☐ New in past 3 months
Decrease in appetite	☐ No ☐ Yes ☐ New in past 3 months
Change in bowel habits or stools	☐ No ☐ Yes ☐ New in past 3 months
Food intolerance	☐ No ☐ Yes ☐ New in past 3 months
Indigestion	☐ No ☐ Yes ☐ New in past 3 months
Heartburn	☐ No ☐ Yes ☐ New in past 3 months
Abdominal pain	☐ No ☐ Yes ☐ New in past 3 months
Belching	☐ No ☐ Yes ☐ New in past 3 months
Nausea	☐ No ☐ Yes ☐ New in past 3 months
Vomiting	☐ No ☐ Yes ☐ New in past 3 months
Diarrhea	☐ No ☐ Yes ☐ New in past 3 months
Flatulence or gas	☐ No ☐ Yes ☐ New in past 3 months

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Genitourinary (reproductive and urine) Review	
Urinary urgency	☐ No ☐ Yes ☐ New in past 3 months
Feel the need to urinate frequently	☐ No ☐ Yes ☐ New in past 3 months
Pain with urination	☐ No ☐ Yes ☐ New in past 3 months
Excessive urination at night	☐ No ☐ Yes ☐ New in past 3 months
Abnormally small amounts of urine	☐ No ☐ Yes ☐ New in past 3 months
Stones	☐ No ☐ Yes ☐ New in past 3 months
Infections or discharge	☐ No ☐ Yes ☐ New in past 3 months
Dribbling, incontinence or leakage	☐ No ☐ Yes ☐ New in past 3 months
Genital sores	☐ No ☐ Yes ☐ New in past 3 months
Painful menstruation (females)	☐ No ☐ Yes ☐ New in past 3 months
Changes in color of urine	☐ No ☐ Yes ☐ New in past 3 months
WOMEN ONLY: Is there any chance you are pregnant?	☐ No ☐ Yes weeks:
Musculoskeletal (muscles & joints) Review	
Pain in back or neck	☐ No ☐ Yes ☐ New in past 3 months
Pain in shoulders, arms, hips or legs	☐ No ☐ Yes ☐ New in past 3 months
Misalignment	☐ No ☐ Yes ☐ New in past 3 months
Stiffness in muscles or joints	☐ No ☐ Yes ☐ New in past 3 months
Joint swelling	☐ No ☐ Yes ☐ New in past 3 months
Decrease in range of motion	☐ No ☐ Yes ☐ New in past 3 months
Popping or cracking of joints	☐ No ☐ Yes ☐ New in past 3 months
Arthritis or degeneration	☐ No ☐ Yes ☐ New in past 3 months
Unable to use body as normal	☐ No ☐ Yes ☐ New in past 3 months
History of fractures	☐ No ☐ Yes ☐ New in past 3 months
Do you have a bulging or herniated disc?	☐ No ☐ Yes ☐ New in past 3 months
Do you have you have scoliosis, spina bifida or fused/abnormal vertebrae?	☐ No ☐ Yes ☐ New in past 3 months
Do you have osteoporosis, osteopenia, or ankylosing spondylitis?	☐ No ☐ Yes ☐ New in past 3 months
Integumentary (skin) Review	
Rashes, marks, color changes, nodules, tumors, or severe dryness or severe itching of the skin	☐ No ☐ Yes ☐ New in past 3 months
Neurological (brain and nerves) Review	
Do you have a history of seizures or neurological disease such as MS, Parkinson's or lupus?	☐ No ☐ Yes ☐ New in past 3 months
Changes in sight	☐ No ☐ Yes ☐ New in past 3 months
Changes in smell	☐ No ☐ Yes ☐ New in past 3 months
Changes in taste	☐ No ☐ Yes ☐ New in past 3 months
Changes in hearing	☐ No ☐ Yes ☐ New in past 3 months
Tinnitus or ringing in the ears	☐ No ☐ Yes ☐ New in past 3 months
Headaches	☐ No ☐ Yes ☐ New in past 3 months
Paresthesias or numbness, tingling or burning	☐ No ☐ Yes ☐ New in past 3 months
Weakness in arms, legs, neck, or trunk	☐ No ☐ Yes ☐ New in past 3 months
Balance problems	☐ No ☐ Yes ☐ New in past 3 months
Speech problems or problems making proper words	☐ No ☐ Yes ☐ New in past 3 months
Communication problems	☐ No ☐ Yes ☐ New in past 3 months
Cognitive or thinking problems	☐ No ☐ Yes ☐ New in past 3 months
Changes in emotional control	☐ No ☐ Yes ☐ New in past 3 months
Changes in vision	☐ No ☐ Yes ☐ New in past 3 months
Bumping into objects	☐ No ☐ Yes ☐ New in past 3 months
Difficulties with driving	☐ No ☐ Yes ☐ New in past 3 months
Blacking out or fainting	☐ No ☐ Yes ☐ New in past 3 months
Tripping or falling	☐ No ☐ Yes ☐ New in past 3 months

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Psychiatric (mind) Review	
Depression	☐ No ☐ Yes ☐ New in past 3 months
Sadness	☐ No ☐ Yes ☐ New in past 3 months
Anxiety	☐ No ☐ Yes ☐ New in past 3 months
Personality changes	☐ No ☐ Yes ☐ New in past 3 months
Social changes	☐ No ☐ Yes ☐ New in past 3 months
Phobias	☐ No ☐ Yes ☐ New in past 3 months
Endocrine (hormones) Review	
Heat intolerance	☐ No ☐ Yes ☐ New in past 3 months
Excessive sweating	☐ No ☐ Yes ☐ New in past 3 months
Abnormally large amounts of urine	☐ No ☐ Yes ☐ New in past 3 months
Abnormally thirsty	☐ No ☐ Yes ☐ New in past 3 months
Changes in appetite	☐ No ☐ Yes ☐ New in past 3 months
Hair loss	☐ No ☐ Yes ☐ New in past 3 months
Dizziness	☐ No ☐ Yes ☐ New in past 3 months
Pain in the abdomen	☐ No ☐ Yes ☐ New in past 3 months
Extreme fatigue	☐ No ☐ Yes ☐ New in past 3 months
Allergy Review	
Known allergies to drugs	☐ No ☐ Yes ☐ New in past 3 months
Known allergies to foods	☐ No ☐ Yes ☐ New in past 3 months
Known allergies to insects	☐ No ☐ Yes ☐ New in past 3 months
Skin rashes	☐ No ☐ Yes ☐ New in past 3 months
Unexplained trouble breathing	☐ No ☐ Yes ☐ New in past 3 months
Bleeding tendency	☐ No ☐ Yes ☐ New in past 3 months
Previous transfusions	☐ No ☐ Yes ☐ New in past 3 months
Rh incompatibility	☐ No ☐ Yes ☐ New in past 3 months
Lymph node enlargement	☐ No ☐ Yes ☐ New in past 3 months
Eyes, Ears, Nose & Throat Review	
Nose bleeds	☐ No ☐ Yes ☐ New in past 3 months
Nose obstruction or discharge	☐ No ☐ Yes ☐ New in past 3 months
Dental difficulties	☐ No ☐ Yes ☐ New in past 3 months
Gingivitis or gum bleeding	☐ No ☐ Yes ☐ New in past 3 months
Dentures	☐ No ☐ Yes ☐ New in past 3 months
Bumps or nodules in your neck	☐ No ☐ Yes ☐ New in past 3 months
Tenderness in the front of the neck	☐ No ☐ Yes ☐ New in past 3 months
Double vision, blind spots, tearing, blurriness or eye pain	☐ No ☐ Yes ☐ New in past 3 months
Bumping into objects	☐ No ☐ Yes ☐ New in past 3 months
Difficulties driving	☐ No ☐ Yes ☐ New in past 3 months

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PLEASE LIST ALL PROVIDERS YOU HAVE SEEN FOR THESE ISSUES

1) Provider or facility: Email: Date of initial visit:

City/State: Phone: Fax: Still seeing provider? ☐ No ☐Yes

Pick ONLY 1 Provider Type From This Column	**You may pick multiple choices in this column**
☐ Emergency Center	☐ Consultation
☐ General Practice M.D. / PCP	☐ Examination
☐ Pain Management Doctor	☐ Treatment recommendations
☐ Chiropractic	☐ Adjustments
☐ Eye Doctor	☐ Exercises or Stretching / Electric Stimulation
☐ Dentist	☐ Dental or TMJ work
☐ Psychologist	☐ Balance/Vestibular Therapy
☐ Physical Therapy	☐ Vision Therapy
☐ Occupational Therapy	☐ Prescription for medications / injections
☐ Massage Therapy	☐ Prescription for glasses or equipment
☐ Other:	☐ Massage, trigger point, or dry needling

The intervention from this provider: ☐ Helped ☐ Did not help ☐ Made condition worse ☐ Other:

Were you referred to another provider? ☐ No ☐ Yes Who?

☐ Xrays of: ☐ Head ☐ Neck ☐ Middle back ☐ Low back ☐ Arms or legs ☐ Other:

☐ CT of: ☐ Head ☐ Neck ☐ Middle back ☐ Low back ☐ Arms or legs ☐ Other:

☐ MRI of: ☐ Head ☐ Neck ☐ Middle back ☐ Low back ☐ Arms or legs ☐ Other:

☐ Other Tests?

☐ You may communicate and share records with this provider regarding this case. **Patient Signature:**

1) Provider or facility: Email: Date of initial visit:

City/State: Phone: Fax: Still seeing provider? ☐ No ☐Yes

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INFORMED CONSENT

Some risk is assumed in all treatment modalities, including chiropractic adjustments. Manipulation or adjustment of the human frame carries small risk of injury to weakened or hidden pathology of the vertebral artery in the neck causing death or stroke in reported 1 per 400,000 cases to 1 per 10 million cases. Every effort is made to screen for this and use methods with the lowest risk. Your doctor of chiropractic is the highest licensed professional for specific and safe adjustment of the human frame. Other complications may rarely include; strain, sprain, dislocation, fracture, disk aggravation, physiotherapy burns, muscle soreness, aches, or other injury. Please ask your doctor of chiropractic if you have any questions.

Subluxation is a misaligned and/or "stuck" joint or tissue, which is found to cause nerve impingement. This interferes with any organ, tissue, or blood vessel supplied by that nerve. Your doctor of chiropractic is trained to look for and find these subluxations, and to correct them with a chiropractic adjustment. Please do not "pop" or "crack" your joints using a thrust of any kind, nor have an unlicensed person do it for you. Not only can you be hurt, you most likely will not achieve the correction you are looking for. Proper stretching can be very beneficial, and painless popping sounds may be heard and are normal, as long as no forceful thrust or impulse is applied.

It should be noted that any spinal misalignment or subluxation left untreated will cause continued joint degeneration and mobility. The improper joint motion, in turn, will likely cause altered nerve flow to the brain, causing functional brain-based problems over time. After a specific adjustment some people experience the effects of renewed nerve flow and circulation to impinged areas that were restricted by their subluxation. These historically have been changes in; sweating patterns, increased respiratory capacity, faster bowel transit time, increased bowel movement frequency, shift in center of balance perception, sleep pattern changes, shoe fit and clothing measurements, differences in walking (gait), and various organ function changes. These subside quickly as the tissue adjusts itself to the restored nerve flow, but may be temporarily necessary in order for the tissue cells to excrete stored wastes.

Nutritional protocols used in this office are based upon research done by our nutritional supplementation manufacturer/suppliers and the protocols established by them. While the nutritional products we prescribe are safe, it should be noted that anything that has the power to do good can also cause you harm. Make sure to follow the doctors recommendations for product use, and to report any adverse symptoms experienced while using them.

Brain-based, or neurologic, work is accomplished using protocols widely supported by the chiropractic neurology profession. These treatment modalities are designed to engage specific regions of your brain or nervous system in an effort to create improved function of global brain health. Nutritional supplementation and dietary recommendations are commonly made to facilitate this therapy. Negative side effects are rare when the work is done appropriately. Make sure you follow the doctors recommendations while engaged in a brain-based program.

_____ _____

Patient/Guardian Signature Date Signed

Health History Form

TODAY'S DATE:

PATIENT INFORMATION			
Last Name:	**First Name:**	**MI:**	**Birth Date:**

NOTICE OF PRIVACY PRACTICES (pg 1)

The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed and how you can have access to this information. Please review it carefully.

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 April 14, 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 or 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 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 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 Patients 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 you with your healthcare or with payment for you healthcare, but only if you agreed 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 the 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 health care. 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 filled prescriptions, medical supplies, 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.

Health History Form

TODAY'S DATE:

PATIENT INFORMATION			
Last Name:	**First Name:**	**MI:**	**Birth Date:**

NOTICE OF PRIVACY PRACTICES (pg 2)

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 heath 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 ot authorized federal officials health information require 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 voice mail messages, postcards, or letters).

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 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 $.20 for each page, $16.79 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 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 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.

Health History Form

TODAY'S DATE:

PATIENT INFORMATION			
Last Name:	**First Name:**	**MI:**	**Birth Date:**

NOTICE OF PRIVACY PRACTICES (pg 3)

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about 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 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.

Contact Officer: Brad Gulla, D.C.
Telephone: (719) 380-1038 Fax: (719) 380-8055
E-mail: drgulla@n8colorado.com
Address: 3510 Galley Road, Suite 104
Colorado Springs, CO 80909

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____	_____	_____
Patient Signature	Patient's Printed Name	Date