



Lydia H. Knutson, D.C. • Susan Grace, D.C.  
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*This information is strictly confidential. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please be as accurate as possible.*

*I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that all examinations and treatments are to be paid for as they are received unless definite financial arrangements are made in advance.*

*I hereby authorize Dr. Lydia Knutson or Dr. Susan Grace to examine and treat my condition as she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.*

Signature of Patient, Spouse or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE DO NOT WEAR PERFUMES, AFTERSHAVES OR OTHER SCENTS TO THIS OFFICE.**  
**SOME PATIENTS ARE ALLERGIC.**

### PATIENT INFORMATION

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ Employer \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Type of work \_\_\_\_\_

\_\_\_\_\_ If retired, what was your occupation? \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Email \_\_\_\_\_ Gender:  F  M  Other

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Marital Status:  S  M  W  D  Partnered Height: \_\_\_\_ ft \_\_\_\_ in Current weight: \_\_\_\_\_

Name of Spouse/Partner \_\_\_\_\_ Lowest adult weight \_\_\_\_ Highest \_\_\_\_ Desired \_\_\_\_

Spouse's Occupation \_\_\_\_\_ Medical Doctor \_\_\_\_\_

Travel time to this office \_\_\_\_\_ Referred to our office by \_\_\_\_\_

Name(s) and Age(s) of Children \_\_\_\_\_

Other Household Members (include extended family, non-family and pets) \_\_\_\_\_

Name of person responsible for payment of professional services \_\_\_\_\_

### CURRENT HEALTH REPORT

Please describe the principal health problems for which you came to this office. Include approximate date of onset.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What are your long-term goals in coming to this office? \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Are your present complaints due to an injury?  no  yes  auto accident  other \_\_\_\_\_

Is your condition getting progressively worse?  no  yes • Pain is:  constant  comes and goes

Is your condition interfering with your:  work  sleep  daily routine  other \_\_\_\_\_

Have you lost any days of work?  no  yes Dates \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

Have you had this or a similar condition before?  no  yes If yes, explain \_\_\_\_\_

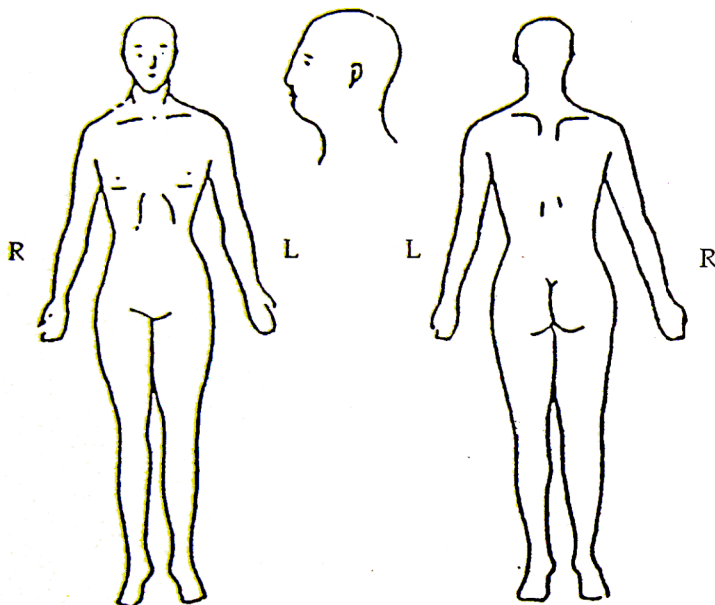
Has anyone in your family had a similar condition before?  no  yes If yes, who? \_\_\_\_\_

Past chiropractic treatment  no  yes When? \_\_\_\_\_ Explain \_\_\_\_\_

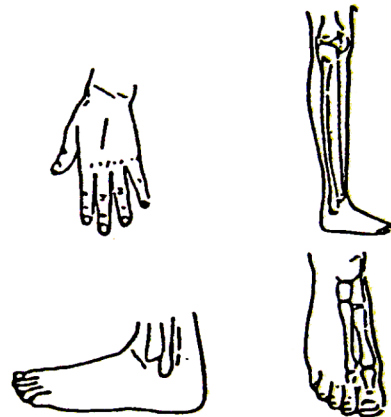
Have you seen any other physicians for this condition? \_\_\_\_\_

List diagnoses and describe treatment \_\_\_\_\_

Please mark area and type of pain on the drawings using the codes listed below.



N = Numbness P = Pain  
T = Tingling A = Ache  
S = Soreness ST = Stiffness



Do you wear:  Glasses/contacts  Heel lifts  Orthotics  Dental night guard

Did/do you wear dental braces?  no  yes When? \_\_\_\_\_

Have you been treated for any other health condition by a physician in the last year?  no  yes If yes, explain \_\_\_\_\_

Are you currently taking prescription medication?  no  yes If yes, what? \_\_\_\_\_

Have you ever been on frequent or prolonged antibiotic therapy (such as erythromycin, penicillin, tetracycline, etc.)?

Please describe: \_\_\_\_\_

Current non-prescription medications (laxatives, aspirin, antihistamines, decongestants, stimulants, etc.) \_\_\_\_\_

Are you currently taking any vitamins or supplements?  no  yes If yes, what? \_\_\_\_\_

Allergies or sensitivities to drugs, foods, pollens, chemicals, animals, etc. \_\_\_\_\_

## HABITS OF DAILY LIVING

**Exercise:**  None  Moderate  Heavy •  <1 per week  1-3 times per week  Daily • Hours/ week \_\_\_\_\_

**Work Activity** (check all that apply):  Sitting  Standing  Walking  Light Labor  Heavy Labor

**Stress level:**  High  Moderate  Low • Do you do any stress reduction or relaxation activities such as meditation, yoga, prayer, etc.? \_\_\_\_\_

Are you currently on psychotropic medication or receiving psychological counseling? Please describe: \_\_\_\_\_

What are your favorite hobbies or other life interests? \_\_\_\_\_

**Sleep habits:** Hours per night \_\_\_\_\_ Restless or restful? \_\_\_\_\_ Do you dream? \_\_\_\_\_

What time do you go to bed? \_\_\_\_\_ Do you sleep through the night? \_\_\_\_\_

**Alcohol consumption:** Drinks per week \_\_\_\_\_ Have you ever felt the need to cut down? \_\_\_\_\_

**Tobacco consumption:** Do you smoke? \_\_\_\_\_ How much per day? \_\_\_\_\_ How long? \_\_\_\_\_

Did you ever smoke? \_\_\_\_\_ How much for how long? \_\_\_\_\_ When did you stop? \_\_\_\_\_

**Non-medical drug use:** Type and frequency \_\_\_\_\_

**Chemical exposure:** Do you regularly use:  Cosmetics  Perfumes  Aftershaves  Scented soaps/products

Do you have amalgam dental fillings?  yes  no • Any prolonged exposure to paints or solvents?  yes  no

Other known notable chemical exposures: \_\_\_\_\_

**Diet:** Do you eat regular meals?  yes  no • Do you sit down for meals?  yes  no • Do you normally eat or drink between meals?  yes  no What? \_\_\_\_\_

How often does your diet consist mainly of some or all of the following: salads, whole grains, eggs, fresh fruits and vegetables, lean meats, beans or legumes?  rarely  sometimes  often  almost always

Are you a vegetarian?  yes  no • Do you eat processed foods with artificial colorings, flavorings or preservatives (e.g. bologna, sausage, cheese spreads, baked goods)?  rarely  sometimes  often

Do you eat "fast food"?  rarely  sometimes  often What and how often? \_\_\_\_\_

Do you add sugar to coffee, tea, cereals, other foods?  yes  no • Do you use artificial sweeteners?  yes  no

How many servings of:

___ Fruit/day	___ Fish/week	___ Water/day	___ Tea/day
___ Vegetables/day	___ Fowl/week	___ Soft Drinks/day	___ Chocolate/Cocoa/day
___ Sweets/day	___ Red meat/week	___ Coffee/day	___ Cow dairy/day (cheese, milk, yogurt)

# GENERAL HEALTH HISTORY

List any major accidents, serious falls or injuries (with dates) \_\_\_\_\_

Broken bones, cranial injuries \_\_\_\_\_

List surgeries/hospitalizations (with dates) \_\_\_\_\_

List X-rays or special imaging taken in the last 10 years and their dates \_\_\_\_\_

Please check all that you have or have had:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Alcoholism                | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Lupus              | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Dyslexia            | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatism           |
| <input type="checkbox"/> Appendicitis              | <input type="checkbox"/> Diverticulitis      | <input type="checkbox"/> Malaria            | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> ADD/ADHD                  | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Scoliosis            |
| <input type="checkbox"/> Osteoarthritis            | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Mental Illness     | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Grave's Disease     | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Cerebral Palsy            | <input type="checkbox"/> Hashimoto's Disease | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Typhoid Fever        |
| <input type="checkbox"/> Chronic Fatigue           | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteopenia         | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Colitis/Bowel Disease     | <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Whooping Cough       |
| <input type="checkbox"/> Crohn's Disease           | <input type="checkbox"/> Influenza           | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Learning Disability |   |   |

Have you ever lived or traveled outside of the United States?  yes  no • Had travelers diarrhea?  yes  no

Have you ever been tested for intestinal parasites?  yes  no • Been treated for intestinal parasites?  yes  no

If yes, please describe when, and what parasite(s) \_\_\_\_\_

# CHILDHOOD HISTORY

Were you breast or bottle fed? \_\_\_\_\_ Vaginal birth or C-section? \_\_\_\_\_ Complications? \_\_\_\_\_

Childhood illnesses:

- |                                     |   |   |   |
|-------------------------------------|---|---|---|
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Colic          | <input type="checkbox"/> Persistent Diaper Rashes | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Recurrent Colds          | <input type="checkbox"/> Frequent Antibiotics |

Was your home life (check all that apply):

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Loving                               | <input type="checkbox"/> Fun                  | <input type="checkbox"/> Loud                           | <input type="checkbox"/> Alcoholic            |
| <input type="checkbox"/> Supportive                           | <input type="checkbox"/> Educational          | <input type="checkbox"/> Argumentative                  | <input type="checkbox"/> Single Parent        |
| <input type="checkbox"/> Peaceful                             | <input type="checkbox"/> Stressful            | <input type="checkbox"/> Verbally Abusive               | <input type="checkbox"/> Lonely or Neglectful |
| <input type="checkbox"/> Filled with positive extended family | <input type="checkbox"/> Financially Stressed | <input type="checkbox"/> Physically or Sexually Abusive |   |

Comments: \_\_\_\_\_

# FAMILY HISTORY

	Diabetes	Heart Disease/High Blood Pressure	Cancer	Musculoskeletal Problems	Other _____
Grandparent(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of siblings _____	Sibling age(s) and health status _____				
Age of biological parents _____	If deceased, age and cause: _____				

## SYSTEMS REVIEW

Please check appropriate box for any of the following symptoms that you have now or had previously.

P = In the past    O = Occasionally in the present    C = Constantly in the present

P	O	C	GENERAL	P	O	C	MUSCLES & JOINTS	P	O	C	CARDIOVASCULAR	P	O	C	RESPIRATORY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps when walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain, numbness or tingling in:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart	<b>GENITO-URINARY</b>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling ankles				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms	<b>EYE/EAR/NOSE/THROAT</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbows					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thirst Abnormal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<b>GASTRO-INTESTINAL</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Farsightedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night urination
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nearsightedness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tailbone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<b>FOR WOMEN ONLY</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (piles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal parasites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breast
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<b>SKIN</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stuffy nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant at this time?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Last Pap _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cycle: _____ days
<b>THYROID</b>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last period: _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Underactive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental decay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES

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

I, \_\_\_\_\_, have received a  
(Please Print Name)

copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(If Patient is a Minor, Please Print Name)

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For Office Use Only

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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 room situation prevented us from obtaining acknowledgement
- € Other (Please specify) \_\_\_\_\_



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## 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.

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### 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 must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for a treatment or upon request. If we make a change in our privacy terms the change will apply for all of your health information in our files.

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.

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### 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 or disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use or 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 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 location) a family member, your personal representative or another person responsible for your care, or your location, 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 circumstance, 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 best professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up x-rays or 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 institutions or enforcement officials having lawful custody of protected health information of inmate or patients 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).

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expense such as copies and staff time. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

**Disclosure Accounting:** You have the right to receive a list of instances in which we have disclosed your health information for purposes, other than treatment, payment, health care 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). If we do not agree to your restrictions, you may drop your request or you are free to seek care from another healthcare provider.

**Alternative Communications:** You have the right to request that we communicate with you about your health information by alternative means or at 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 Website or by electronic mail (email), you are entitled to receive this Notice in written form.

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## 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 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 may also 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.

**To Contact us:**

Lydian Chiropractic  
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(617) 876-9099