ABUNDANT
LIFE
CHIROPRACTIC

(608) 247-9229 abundantlifehousecalls@gmail.com

New Patient Paperwork

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____
Phone: _____ Email: _____
Preferred Method of Contact: (*please circle*) text / call / email Date of Birth: _____/_____/_____
Referred by: _____
Emergency Contact Name: _____
Relationship: _____ Phone Number: _____

Patient Condition

Reason for visit: _____
Is this condition the result of an accident? YES or NO If yes, please explain: _____
How did the injury occur? _____ When did the symptoms occur? _____
Does it interfere with your □work □sleep □recreation □daily routine
Activities or movements that are difficult or painful to perform: □sitting □standing □bending □walking □lying down Circle your pain on the below scale of 0, being no pain, to 10, being extreme pain:
AT REST 0 1 2 3 4 5 6 7 8 9 10 **AND** *WITH ACTIVITY* 0 1 2 3 4 5 6 7 8 9 10

Allergies

Are you allergic to any medications? □YES □NO If yes, which?_____
Are you allergic to any of the following? □Bee Sting □Latex □Dairy □Mold □Eggs □Nuts □Peanuts □Shellfish □Pollen □Wheat □Other:_____ Describe the reaction:_____

Smoking

Do you currently smoke or e-vape tobacco of any kind? □Yes □Former Smoker □Never Smoker
If yes, how often do you smoke? □Every day □Occasionally

Medications

If there are no current medications, check here: ⏭
Do you currently use any recreational drugs? Yes No

	Medication Name	Quantity/Dosage (ex. 1 tab, 5 mg)	Frequency (ex. 2 times a day)	Start Date
1				
2				

3				
4				
5				

Social History

Work Activity: What is your job description?

_____

What do you do most of the day at work? ☐Standing ☐Sitting ☐Heavy Labor ☐Light Labor ☐
Other: _____ What job did you do most of your life? _____
How would you describe the physical stress at work? ☐Low ☐Medium ☐High

Diet/Nutrition: Are you on a special diet? ☐Yes ☐No If yes, for what reason? _____
Is your weight a concern for you emotionally or physically? ☐Yes ☐No
Have you gained or lost 10 pounds or more within the last 6 months without trying? ☐Yes ☐No

Describe your usual eating habits in the table below:

Breakfast	Lunch	Dinner	Snack

How many 8 ounce glasses of water do you drink in a day? _____
Alcohol Use: Now? ⏭ Yes ⏭ No Amount/Weekly____ How long? _____ Years/Months
In the past? ⏭ Yes ⏭ No Amount/Weekly____ How long? _____ Years/Months

How many coffee caffeine drinks do you drink a day? Cups ____ None ____
How many soda caffeine drinks do you drink a day? Cans ____ None ____

Current Vitamins, Minerals, Herbs, etc. List ANY/ALL non-prescription items you are CURRENTLY taking.

	Vitamin, Mineral, Herbs, or Non-prescription	Quantity/Dosage (ex. 1 tab, 5 mg)	Frequency (ex. 2 times a day)	Start Date
1				

2				
3				
4				
5				

Health Review

How many hours of sleep are you getting per night? Less than 5, 6-8, 8-10, 10 or more hours
How would you rate your sleep on the following scale? Fully Rested 0 1 2 3 4 5 6 7 8 9 10 No/Poor Sleep
How many days a week do you exercise for 30 minutes or more? 0, 1-2, 3-4, 5-6, 7
How would you rate the intensity of your exercise? High Intensity 0 1 2 3 4 5 6 7 8 9 10 No Exercise
How would you rate your physical stress level? No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed
How would you rate your emotional stress level? No stress 0 1 2 3 4 5 6 7 8 9 10 Very stressed
List your major Stressors:

_____

What are your health goals?

_____

In addition, talk to your doctor about other areas which may be affecting your health-such as worries about finances, social support, and alcohol, tobacco and/or drug use. Please write down anything you would like your doctor to bring up in your appointment.

_____

Personal Health History

Are you currently under the care of a Healthcare Provider or any other doctor? □Yes □No
If yes, for what condition(s)_____

_____

Provider's Name _____ Phone Number_____
Has any doctor diagnosed you with Hypertension recently? □Yes □No
If yes, describe: _____
Has any doctor diagnosed you with Diabetes recently? □Yes □No
If yes, was your blood lab-work test for hemoglobin A1c >9.0%? □Yes □No □Not Sure
If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? □Yes □No

Do you wear any of the following? □Heel Lifts □Innersoles □Arch Supports □Orthotics
□Other_____ For how long? _____
Were they prescribed by a doctor? □Yes □No

Have you seen a chiropractor in the past? □Yes □No Date of last visit_____
If yes, name and location of previous Chiropractor_____
Phone Number_____ Were you satisfied with your care? □Yes □No
Why?_____

Adult Illnesses (Please circle all that apply)

ADD	Cystic Kidney Disease	High Blood Pressure	Psychiatric Condition
Alzheimer's	Depression	Influenza Pneumonia	Scoliosis
Arthritis	Diabetes	Liver Disease	Seizures
Asthma	Eczema	Lung Disease	Shingles
Cancer	Emphysema	Lupus Erythema	STD's
Cerebral Palsy	Eye Problems	Multiple Sclerosis	Suicide Attempt(s)
Chicken Pox	Fibromyalgia	Parkinson Disease	Thyroid Problems
Colitis	Heart Disease	Unspecified Pleural Effusion	Vertigo
CRPS (RSD)	Hepatitis	Pneumonia	Other:
CVA (Stroke)	HIV	Psoriasis	

Injuries (Please circle all that apply and list date next to injury of occurrence)

Back Injury	Fracture	Laceration (severe)
Broken Bones	Head Injury	Motor Vehicle Accident
Disability(ies)	Industrial Accident	Soft Tissue Injury
Fall (severe)	Joint Injury	Other:

Surgeries

	Date	Procedure (ex. Knee Repair)	Description	
1				In Patient/Out Patient
2				In Patient/Out Patient
3				In Patient/Out Patient

Review of Systems

Please indicate if you have any of the following by circling within the box

Constitutional	None	Daytime Drowsiness	Fever	Night Sweats
	Chills	Fatigue	Loss of Appetite	Weight Gain/Loss
Eyes/Vision	None	Cataracts	Itching	Wears Contacts/Glasses
	Blindness	Double Vision	Photophobia	
	Blind Spots	Eye Problems	Tearing	
Ears, Nose and Throat	None	Fainting	History of Head Injury	Runny Nose
	Dizziness	Frequent Sore Throats	Loss of Sense of Smell	Sinus Infection
	Ear Discharge	Headaches	Nosebleeds	
	Ear Pain	Hearing Loss	Nasal Congestion	
Respiration	None	Cough	Shortness of Breath	Wheezing
	Asthma	Coughing up Blood	Sputum Production	Paroxysmal Nocturnal Dyspnea
Cardiovascular	None	Heart Murmur	Orthopnea (Difficulty Breathing Laying down)	Shortness of Breath with Exertion
	Claudication (Leg Pain and Ache)	High Blood Pressure		
		Low Blood Pressure		Ulcers
	Heart Problem	Palpitations	Palpitations	Varicose Veins
Gastrointestinal	None	Belching	Difficulty Swallowing	Jaundice
	Abdominal Pain	Black Tarry Stool	Heartburn	Ulcers
	Abnormal Stool (Color/Consistency)	Constipation	Hemorrhoids	Rectal Bleeding
		Diarrhea	Indigestion	Loss of Bowel Control

Female	None, N/A	Birth Control	Frequent Urination	Vaginal Discharge
	Abnormal Vaginal Bleeding	Breast Lump/Pain	Hormone Therapy	Urine Retention/Incontinence
		Burning Urination	Irregular Menstruation	Cramps
	Currently Pregnant	NOT currently pregnant	Menses are	Regular
	Currently have Menses	Currently DO NOT have menses		Not Regular
	Age of first Menses		Age when menopause began	
	Date of last menstrual period			
	If you have been pregnant in the past, please fill in the appropriate information below			
	Number of complicated pregnancies		Number of uncomplicated pregnancies	
	Number of C-Sections		Number of vaginal deliveries	
	Number of Miscarriages		Number of terminated pregnancies	
Male	None, N/A	Burning Urination	Frequent Urination	Prostate Problems
	Erectile Dysfunction	Hesitancy/ Dribbling	Urine Retention/ Incontinence	
Sexual Health	Do you have any concerns about your sexual health? □Yes □No			
	Are you or have you ever been a victim of domestic violence or sexual abuse? □Yes □No			
Skin	None	Change in skin color	History of Skin Disorders	Rash
	Change in nail texture	Hair Loss	Itching	Skin Lesions/ Ulcers
		Hives	Numbness	Varicosities

Nervous System	None	Limb Weakness	Seizures	Stroke
	Dizziness	Loss of Consciousness	Sleep Disturbance	Unsteadiness of gait/loss of balance
	Facial weakness	Loss of Memory	Slurred Speech	
	Headache	Numbness	Stress	
Psychological	None	Bi-Polar Disorder	Depression	Memory Loss
	Anxiety	Confusion	Insomnia	Mood Change
	Behavioral Change	Convulsions	Loss or Change of Appetite	
Hematologic	None	Bleeding	Blood Transfusion	Fatigue
	Anemia	Blood Clotting	Bruising Easily	Lymph Node Swelling

All of the answers I have given are correct to the best of my knowledge, and I choose to continue with my chiropractic evaluation with Abundant Life Chiropractic at this time.

_____

Signature Date

_____

Signature of Parent or Legal Guardian Relationship

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Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed Chiropractic Physician, Dr. Airn Houlahan.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation AKA “adjustments” involve the doctor placing her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment via cash currency, Venmo, Money Order, or by credit card to Dr. Airn Houlahan upon services rendered. I understand and agree to the space of your home approximately 10x10 sq. feet of usage to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Dr. Airn Houlahan to communicate with my medical physician(s) and/or healthcare specialists about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care or others, regardless of satisfaction of treatment. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Due to the nature of this service being outside of conventional therapy, we do not participate with insurance, and any and all patients worked on will be responsible for payment for services rendered.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. I have also read, or have read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment by this doctor.

Patient Signature: _____ Date: ____/____/_____

Printed Name: _____

CONCIERGE CHIROPRACTIC POLICIES

1. We require a 24-hour cancellation policy for our services. A 50% charge will be added to the bill of the individual if cancellations are made within 24 hours. Situations may vary, so consult with the Doctor prior to treatment if there is an issue regarding payment(s) due.
2. We have the right to not perform any services we do not see appropriate for the presentation of the patient.
3. We reserve the right to refuse service to any and all patients we do not feel comfortable with.
4. If in case of emergency situations such as an acute injury, condition, or illness, please call 9-1-1 instead of our service, or visit your local Emergency Room (ER) or urgent care center for help.
5. We request the patient provide any prior imaging within the last 3 years, especially if it pertains to your chief complaint. We may refer patients out for imaging if we deem it necessary either before or during care.
6. You must complete a phone interview with the clinic prior to the Doctor traveling to your home or residence to provide services listed on our website.
7. You may be asked to participate in filming of techniques or treatments for the purposes of our social media and/or marketing platform. If you do not wish to participate in our filming, you have the right to refuse to take part in it.
8. You must disclose if you have any pets in your home that may in any way interrupt the treatment of the Doctor.
9. You must disclose if you have any young children (age 12 or younger) in the area where the treatment will take place.
10. If the Doctor is running late, she will make sure to contact you either by phone call, text, email notification, or Facebook/Instagram Direct Messages to notify her status.
11. You must provide at least a 10 x 10 (Length by width) space to allow to the Doctor to provide services.
12. Due to the nature of our concierge/house-call business, we do not participate with Medicare, Medicaid, Personal Injury Cases, or any other healthcare insurance agencies.
13. Payment is due upon services rendered either before or after appointments on the same day visit. If there is a discrepancy about a payment, payments or dissatisfaction with services, the Doctor is always willing to have a dialogue with the patient to discuss the issue.
14. If the Doctor has to cancel the appointment at any time, you will receive a full refund or not be required to pay depending on the payment plan discussed. The Doctor will notify you via text message, phone call, email, or Facebook/Instagram Direct Messages regarding a cancellation of an appointment.

15. If participating in a payment plan, payment for the full services are expected up front in full, or as discussed according to the payment plan with the Doctor.
16. Same day appointments may or may not be available depending on schedule availability.
17. Please advise the Doctor who gave the referral, for the patient to seek services at Abundant Life Chiropractic.
18. As a chiropractic physician, we do not “heal” or “cure” any condition or illness. We merely analyze and correct vertebral or extremity subluxations, which are misalignments in the body to restore proper nervous system flow.

Appropriate referrals will be made according to the individual needs of the patient.
I have read and agree to the policies set forth by Dr. Airn Houlahan, DC by my signature below:

_____

Signed Name Date

_____

Printed Name

HIPAA NOTICE OF PRIVACY PRACTICES

ABUNDANT LIFE CHIROPRACTIC
(608) 247-9229

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.

1.Uses and Disclosures of Protected Health Information

Uses and Disclosures 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 healthcare 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 hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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 sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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, 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 are 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 and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must 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 physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

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

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in the reasonable anticipation of, or use 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, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in our best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

You have the right to request to receive confidential communications from us by alternative 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 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 and will inform you by mail of any changes. 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 became effective on/or before **March 2020.**

We are required by law to maintain the privacy of, and provide 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 HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____Signature_____Date_____