



777 Concord Avenue, Suite 301 • 617-876-9099 tel.
Cambridge, MA 02138 • 617-876-9011 fax

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 _____
Email _____ If retired, what was your occupation? _____
Phone (home) _____ (cell) _____ (work) _____
Date of Birth _____ Age _____ Travel time to this office _____
Gender: F M Other Height: ____ ft ____ in Current weight: _____
Marital Status: S M W D Partnered Lowest adult weight ____ Highest ____ Desired _____
Name of Spouse/Partner _____ Medical Doctor _____
Spouse's Occupation _____ 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 _____
Practitioners at the Lydian Center you have previously seen: _____
Enrolled in Medicare, Part B:

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 have felt well? _____

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 _____

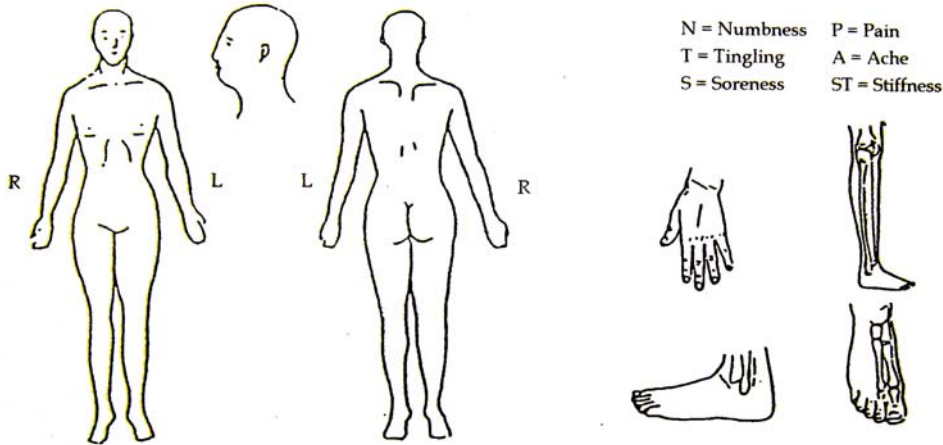
Has anyone in your family had a similar condition before? no yes If yes, who? _____

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.



On a scale of 1-10 rate the level of current pain.
1=no pain, 10=severe pain

Complaint #1 _____

Complaint #2 _____

Complaint #3 _____

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"/> Learning Disability | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <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"/> Autism | | |

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 adopted? _____ If so, at what age? _____ Were you breast or bottle fed? _____
Vaginal birth or C-section? _____ Complications? _____

Childhood illnesses:

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

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"/> Physically Abusive |
| <input type="checkbox"/> Peaceful | <input type="checkbox"/> Stressful | <input type="checkbox"/> Single Parent | <input type="checkbox"/> Verbally Abusive |
| <input type="checkbox"/> Filled with positive
extended family | <input type="checkbox"/> Financially Stressed | <input type="checkbox"/> Lonely or Neglectful | <input type="checkbox"/> 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 write: C = Constantly in the present O = Occasionally in the present P = In the past

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



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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.

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.

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).

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.

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, 777 Concord Avenue Suite 301, Cambridge, MA 02138 tel. (617) 876-9099 fax (617) 876-9011