LYDIAN CHIROPRACTIC

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: ______________________

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 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 ______________________________

____

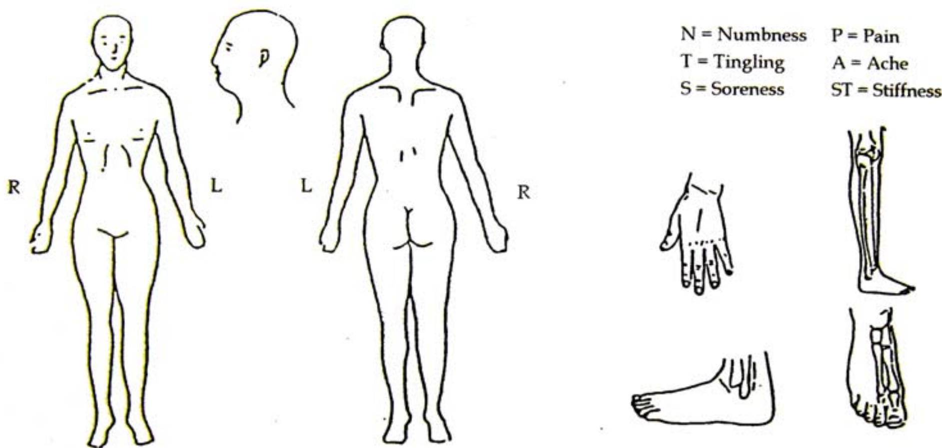
Have you seen any other physicians for this condition? ______________________________

List diagnoses and describe treatment ______________________________

____

____

The following diagram is for office use only.



For office use only.

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:

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

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:

☐ Bronchitis	☐ Allergies	☐ Measles	☐ Rheumatic Fever
☐ Recurrent Colds	☐ Colic	☐ Mumps	☐ Frequent Antibiotics number of times ____
☐ Ear Infections	☐ Persistent Diaper Rashes	☐ Rubella	
☐ Tonsilitis	☐ Bedwetting	☐ Chicken Pox	☐ Other _________________

Was your home life (check all that apply):

☐ Loving	☐ Fun	☐ Loud	☐ Alcoholic
☐ Supportive	☐ Educational	☐ Argumentative	☐ Physically Abusive
☐ Peaceful	☐ Stressful	☐ Single Parent	☐ Verbally Abusive
☐ Filled with positive extended family	☐ Financially Stressed	☐ Lonely or Neglectful	☐ Sexually Abusive

Comments: ____

FAMILY HISTORY

	Diabetes	Heart Disease/High Blood Pressure	Cancer	Musculoskeletal Problems	Other ____________
Grandparent(s)	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐	☐

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

_____ Allergies
_____ Chills
_____ Convulsions
_____ Dizziness
_____ Fainting
_____ Fatigue
_____ Fever
_____ Headache
_____ Loss of Sleep
_____ Nervousness
_____ Night Sweats
_____ Thirst Abnormal
_____ Weight Loss
_____ Weight Gain

GASTRO-INTESTINAL

_____ Belching or gas
_____ Colon trouble
_____ Constipation
_____ Diarrhea
_____ Excessive hunger
_____ Gall bladder trouble
_____ Hemorrhoids (piles)
_____ Intestinal parasites
_____ Jaundice
_____ Liver trouble
_____ Nausea
_____ Pain over stomach
_____ Poor appetite
_____ Poor digestion
_____ Vomiting

THYROID

_____ Overactive
_____ Underactive
_____ Enlarged

MUSCLES & JOINTS

_____ Arthritis
_____ Bursitis
_____ Hernia
_____ Leg cramps when walking
_____ Low back pain
_____ Musculoskeletal birth defects
_____ Neck pain or stiffness

Pain, numbness or tingling in:

_____ Shoulders
_____ Arms
_____ Elbows
_____ Hands
_____ Hips
_____ Legs
_____ Knees
_____ Feet
_____ Painful tailbone
_____ Paralysis
_____ Poor posture
_____ Sciatica
_____ Stiff neck
_____ Spinal curvature
_____ Swollen joints

SKIN

_____ Boils
_____ Bruising easily
_____ Dryness
_____ Eczema
_____ Psoriasis
_____ Hives or allergies
_____ Itching
_____ Sensitive skin
_____ Skin eruptions

CARDIOVASCULAR

_____ Easy Bruising
_____ Hardening of arteries
_____ High blood pressure
_____ Low blood pressure
_____ Pain over heart
_____ Poor circulation
_____ Rapid heart
_____ Slow heart
_____ Swelling ankles
_____ Varicose veins

EYE/EAR/NOSE/THROAT

_____ Crossed eyes
_____ Dry eyes
_____ Eye pain
_____ Farsightedness
_____ Nearsightedness
_____ Light sensitivity
_____ Earache
_____ Ear discharge
_____ Ear noises
_____ Hearing difficulty
_____ Hearing sensitivity
_____ Nasal obstruction
_____ Nose bleeds
_____ Sinusitis
_____ Stuffy nose
_____ Hay fever
_____ Frequent colds
_____ Hoarseness
_____ Sore throats
_____ Enlarged glands
_____ Enlarged thyroid
_____ Dental decay
_____ Grinding teeth

RESPIRATORY

_____ Asthma
_____ Chest pain
_____ Chronic cough
_____ Difficulty breathing
_____ Spitting blood
_____ Spitting phlegm
_____ Wheezing

GENITO-URINARY

_____ Bed wetting
_____ Blood in urine
_____ Frequent urination
_____ Incontinence
_____ Kidney infection
_____ Kidney stones
_____ Night urination
_____ Painful urination
_____ Prostate trouble

FOR WOMEN ONLY

_____ Cramps or backache
_____ Excessive flow
_____ Hot flashes
_____ Irregular cycle
_____ Lumps in breast
_____ Miscarriage
_____ Painful periods
_____ PMS
_____ Vaginal discharge

☐Y ☐N Pregnant at this time?

Last Pap ______________

Menstrual cycle: ______ days

Date of last period: _________

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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:
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