Peter J. Vapnek, D.C., P.A.
14838 S. Military Trail
Delray Beach, FL 33484
Phone: 561-274-6100

Personal History

Date_____

Name_____ (M/F) _____ Home Phone_____

Address _____

E-mail_____ Cell Phone_____

Birth Date_____ Age_____ Marital Status: Married___Single___Widow(er)__Divorced__ Children____

Occupation_____ Employer _____

Name of Husband or Wife_____

Emergency Contact_____ Phone_____

Referred to this office by_____

Insurance Information

Do you have health insurance? Yes/ No (If No skip this section)

Insurance Company_____

Insured same as patient? Yes/ No Insured Name_____ Insured Gender (M/ F

Patient relationship to insured: Self_____ Spouse _____ Child ____Other_____ Insured D.O.B._____

Accident/ Illness Information

Is condition related to: Employment (Yes / No)

Auto Accident (Yes / No)

Other Accident (Yes / No)

Date of Accident _____/_____/_____ Dates missed from work_____

Presenting Problems

Name _____ Date _____/_____/_____

What is the presenting problem/chief complaint? _____

_____

When did the problem begin? _____

_____

What was the mechanism/cause of injury? _____

_____

Where is the pain located? _____

_____

Rate the pain as it is right now, 0-10 with 0 being no pain and 10 being most excruciating pain _____

Does anything alleviate the pain? _____

Does anything exacerbate the pain? _____

Does the pain radiate into the extremities? _____

Is the pain worse or better at any time of the day? If so, when? _____

Does the pain affect any of your normal daily activities? What/How? _____

_____

Have you sought any medical attention for this complaint yet? If so, who did you see and what was the therapy? _____

_____

_____

What kind of other treatment have you sought for this problem? _____

_____

Have you had any imaging for this problem (x-ray, MRI, CT. etc.)?_____

_____

_____

Describe below any other problems you have been experiencing related to the chief complaint _____

_____

_____

Physician Signature _____ Date _____/_____/_____

REVIEW OF SYSTEMS

(Check any of the following you have or have had)

Name: _____ Date: _____

General Symptoms

__Headaches
__Fever
__Diabetes
__Chills
__Sweats
__Osteoporosis
__Fainting
__Dizziness
__Cancer
__Loss of Sleep
__Fatigue
__Nervousness
__Loss or gained weight
__Numbness or pain in arms, Hands or legs
__Allergies
__Neuropathy
__Depression, mental health

Eyes, ears, nose and throat

__Failing vision
__Blurriness
__Eye pain
__Deafness
__Earache
__Ear noises
__Ear discharge
__Nose bleeds
__Nasal obstruction
__Sore throat
__Hoarseness
__Hay fever
__Asthma
__Dental decay
__Gum trouble
__Thyroid
__Tonsillitis
__Sinus infection
__Nasal drainage
__Enlarged glands
__TMJ
__Jaw clicking

Skin

__Rashes
__Itching
__Bruises easily
__Dryness
__Nail problems
__Varicose veins
__Sensitive skin
__Hives or allergy

Respiratory

__Chronic cough
__BOOP
__COPD
__Spitting up blood
__Chest pain
__Difficult breathing
__Asthma
__Emphysema

Cardio-vascular

__Irregular heart beat
__Pace maker
__High blood pressure
__Low blood pressure
__High cholesterol
__Pain over heart
__Previous heart attacks
__Hardening of the arteries
__Swelling of ankles
__Anemia
__Poor circulation
__Previous strokes
__Blood disorder

Muscle and Joint

__Stiff neck
__Shoulder pain
__Back pain
__Arthritis
__Swollen joints
__Tremors
__Painful tail bone
__Foot trouble
__Pain between shoulders
__Spinal curvature

Genitourinary

__Frequent urination
__Painful urination
__Blood in urine
__Kidney infection or stones
__Bed wetting
__Inability to control urine
__Prostate trouble
__Hernia

Gastrointestinal

__Poor appetite
__Excessive hunger
__Belching or gas
__Nausea
__Vomiting
__Pain over stomach
__Distention of abdomen
__Constipation
__Diarrhea
__Hemorrhoids
__Liver Trouble
__Gall bladder trouble
__Jaundice
__Appendicitis
__Colitis

Female

__Painful menstrual periods
__Hot flashes
__Irregular cycle
__Abdominal cramping
__Previous miscarriage
__Vaginal discharge
__Cancer
__Menopausal symptoms

History

Patient Name:_____ **Date:**_____

List any previous accidents you have had and conditions you have been diagnosed with such as diabetes, cancer, heart disease, etc_____

List any surgeries, major traumas (including concussions and broken bones), illnesses or other hospitalizations

Have you ever been diagnosed with a splondylolisthesis, compression fracture, or other spinal fracture? _____

List all medications you are currently on or have recently taken_____

List all vitamins or other supplements you currently take_____

What are your hobbies/ recreational interests? _____

Yes No Are you currently taking NSAIDS (Ibuprofen, Acetaminophen, etc) How often? _____
Yes No Do you drink alcohol? If yes how many drinks and how often? _____
Yes No Do you smoke? How many packs a day? _____ **How many years?** _____
Yes No Do you use recreational drugs? What/How often? _____
Yes No Are you practicing risky sexual behavior?
Yes No Do you exercise on regular basis? How? _____
Yes No Do you drink water on a regular basis? How many glasses a day? _____
Yes No Do you have difficulty sleeping soundly through the night? _____
Yes No Do you feel fatigued on a regular basis?
Yes No Do you have allergies? _____
Yes No Do you eat healthy? Briefly explain your diet_____

Yes No Have you been to a chiropractor before? If so, why and when? _____

HIGH MED LOW What is your level of stress? Explain_____

Physician signature: _____ **Date:** _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: **I have had the following unusual risks of my case explained to me.**
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name	Signature	Date

WITNESS:

Printed Name	Signature	Date

Peter J. Vapnek, D.C., P.A.
14838 S. Military Trail
Delray Beach, FL 33484
PH: (561) 274-6100

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance companies.

I understand that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment to be made directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

NAME: _____

SIGNATURE: _____

S.S.# _____

DATE: _____

HIPAA Notice of Privacy Practices

PETER J. VAPNEK
CHIROPRACTIC & MASSAGE CTR.
14838 S. MILITARY TRAIL
DELRAY BEACH, FL 33484

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 health care 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, as necessary, 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 as 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 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 this 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 physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

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 your 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

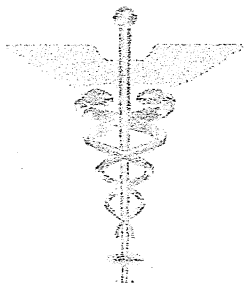
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

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_____



Financial Hardship Agreement

To Whom It May Concern:

By my signature below I am requesting that my doctor reduce normal and customary fees charged so as to allow me to receive chiropractic care. My financial circumstances are such that if I were to pay the customary fees charged I would be forced (due to economic reasons) to not receive care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my Insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship I am only making partial payment.

Patient Name (PRINT):_____

Patient Signature:_____

Witness Signature:_____

Date:_____