Consent to the Use and Disclosure of Health Information for Chiropractic Care, Payment, or Healthcare Operations by the office of:

Tammy M. Kaminski, D.C.

Cedarcrest Chiropractic * Kaminski Wellness Center

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, wellbeing, concerns, symptoms, examination and test results, diagnoses, care, and any plans for future care. I understand that this information serves as:

- a basis for planning my care
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and health information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail or Email a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out care, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I consent to the use and disclosure of my health information for chiropractic care, payment, and healthcare operations as described in the notice of information practices.

_____ _____

Signature of Patient or Legal Representative | Witness

_____ September 23, 2013

Date | Notice Effective Date

_____Accepted _____Denied

_____ _____ _____

Dr.'s Signature | Title | Date

Dr. Tammy M. Kaminski
*Holistic Family Care * Wellness Education*
www.KaminskiWellness.com
(973) 228-6624
Cedarcrest Chiropractic
616 Bloomfield Ave., Ste. 3C, West Caldwell, NJ 07006

A Dr. Hallowell Protocol
SHINE *for* Doctors
Special Help Integrating Neurological Experience ™

ADULT HEALTH HISTORY

Name of Patient		Date	
Gender ☐ Male ☐ Female		Date of Birth / /	Age
Address		Phone Numbers:	Home
Address			Work
			Cell
Occupation			
Emergency Contact			

FAMILY HISTORY

Family history can often be helpful in understanding an individual's problems.
Please check any box that applies:

Mother's highest education level:			
Father's highest education level:			
Please check any box that applies:			
Has anyone in the family had:	***Siblings***	***Parents***	***Extended Family***
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

Please list all family members (in or out of house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?

Parents are: Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed ☐

BIRTH HISTORY

Do you have any information with regard to your birth history? _____

DEVELOPMENTAL HISTORY:

Do you have any information with regard to your infant health status?
For example, were you hospitalized, or had any serious health issues?

MEDICAL HISTORY

Are you regularly checked by the following:

☐ Medical Doctor ☐ Chiropractor ☐ Osteopath ☐ Naturopath ☐ Dentist ☐ Other

Do you have/had braces on your teeth?	☐ Yes	☐ No
Do you have any amalgam fillings? How many?	☐ Yes	☐ No
Do you complain of any ongoing physical pains? (headaches, stomach aches, muscle/joint aches, or growing pains)	☐ Yes	☐ No
Do you suffer from dry skin, dandruff, hard skin on elbows, bumps on the outside of the arms, cracked heels, excessive thirst/urination?	☐ Yes	☐ No

Please list all of your medical and/or psychological diagnoses, past and present:

Please list all current prescription medications:

Are you exposed to a toxic environment (including passive smoking or industrial chemicals)?	☐ Yes	☐ No
Have you had any serious falls, physical traumas, or physical injuries?	☐ Yes	☐ No

Please list:

Have you ever been involved in a motor vehicle accident?	☐ Yes	☐ No

Please list:

Has your hearing been tested?	☐ Yes	☐ No
When was your last hearing test?		
Has your vision been tested?	☐ Yes	☐ No
When did you last visit the optometrist?		
Do you wear glasses/contact lenses?	☐ Yes	☐ No

Have you been hospitalized? ☐ Yes ☐ No
If Yes, for what? _____

Have you had any surgeries? ☐ Yes ☐ No
If Yes, for what reason? _____

Have you had any surgeries recommended to you that have not been performed? ☐ Yes ☐ No
If Yes, for what? _____

Have you had prior psychotherapy or counseling? ☐ Yes ☐ No
If Yes, for what issue? _____

BEHAVIOUR/MENTAL HEALTH

On a scale of 1 to 10, describe your stress level (circle one).

Personal	1	2	3	4	5	6	7	8	9	10
Occupational	1	2	3	4	5	6	7	8	9	10

Describe any sports or activities you are involved in. _____

Indicate the number of hours a week of "screen time" you use:

Computer _____ Smart Device (phone, iPad, etc.) _____
Computer games (DS, etc.) _____ Television _____

Describe your family relationships; with parents and siblings.

Do you have many friends? _____

Do you excel at, or struggle to build relationships with your peers? ☐ Excel ☐ Struggle ☐ Neither

If you struggle, why do you think that is?

What problems do you have with peers, if any?

☐ None ☐ Bragging to peers ☐ Being Teased
☐ Being physically attacked ☐ Rejected by peers ☐ Overly physically affectionate
☐ Being bullied ☐ Jealous of peers

Do you have self-esteem issues? ☐ Yes ☐ No

Do you feel that you exhibit any of the following symptoms more often than is typical? (Please put a check in front of any that apply)

- ☐ Often touchy/easily annoyed
- ☐ Often defies rules
- ☐ Often angry/resentful
- ☐ Often argues with adults
- ☐ Often loses temper
- ☐ Blames other for mistakes
- ☐ Deliberately annoys
- ☐ Often spiteful/vindictive
- ☐ Refuses to go to work
- ☐ Repeated nightmares
- ☐ Unusual fears
- ☐ Panic attacks
- ☐ Self-conscious/clings
- ☐ Excessive need for reassurance
- ☐ Self-injurious behaviour
- ☐ Worry of future events
- ☐ Repeats certain actions
- ☐ Somatic complaints (headache/stomach)
- ☐ Difficulty maintaining friendships
- ☐ Often bullies/threatens
- ☐ Initiates physical fights
- ☐ Ever been arrested
- ☐ Physically cruel to others
- ☐ Physically cruel to animals
- ☐ Motor or vocal tics
- ☐ Destroys property
- ☐ Deliberately sets fires
- ☐ Lies often
- ☐ Steals
- ☐ Has run away
- ☐ Extreme mood swings
- ☐ Does not show emotions
- ☐ Overreacts to touch/noise
- ☐ Strange or bizarre ideas
- ☐ Used drugs in the past
- ☐ Poor social interactions
- ☐ Gets upset by changes in routine
- ☐ Often irritable
- ☐ Changes in appetite
- ☐ Diminished interest
- ☐ Sleep problems
- ☐ Restlessness or slowed down
- ☐ Fatigues/low energy
- ☐ Feels worthless
- ☐ Becomes tearful easily
- ☐ Often sad
- ☐ Indecisive/can't think
- ☐ Thinks about death
- ☐ Talks about suicide
- ☐ Hurts self
- ☐ Currently uses drugs
- ☐ Currently drinks beer or alcohol
- ☐ Used beer or alcohol in the past
- ☐ Can't stop thinking about things
- ☐ Excessive preoccupation with objects or ideas

Please place a check mark in the column which best describes you:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in work or other activities.				
Often has difficulty sustaining attention in tasks or activities.				
Often does not seem to listen when spoken to directly.				
Often does not follow through on instructions and fails to finish tasks (not due to oppositional behavioral failure to understand directions).				
Often has difficulty organizing tasks and activities.				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort				
Often loses things necessary for tasks or activities				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in situations in which remaining seated is expected				
Often moves about excessively in situations where it is inappropriate (may be limited to subjective feelings of restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversations or activities)				

Childhood conditions had, please check:

☐ measles	☐ mumps	☐ chicken pox	☐ whooping cough
☐ scarlet fever	☐ diphtheria	☐ rheumatic fever	☐ typhoid fever
☐ ear infections	☐ tubes in ears	☐ chronic illness	

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

O = Occasional F = Frequent C = Constant

O	F	C	
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fevers
☐	☐	☐	Headaches
☐	☐	☐	Loss of sleep
☐	☐	☐	Nervousness
☐	☐	☐	Depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Loss of weight
☐	☐	☐	tremors
Muscle & Joint			
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Neck pain
☐	☐	☐	Neck stiffness
☐	☐	☐	Pain between shoulders
Respiratory			
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficulty breathing
☐	☐	☐	Spitting blood
☐	☐	☐	Throat phlegm
☐	☐	☐	wheezing
EYes, Ears, Nose & Throat			
☐	☐	☐	Colds
☐	☐	☐	Crossed eYes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Asthma
☐	☐	☐	Ear aches
☐	☐	☐	Ear discharges
☐	☐	☐	Ear noises
☐	☐	☐	Sinus infections
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Sore throat

O	F	C	
☐	☐	☐	Tonsillitis
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sighted
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sighted
☐	☐	☐	Nosebleeds
Cardio-Vascular			
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
Gastro Intestinal			
☐	☐	☐	Excessive hunger
☐	☐	☐	Burping or gas
☐	☐	☐	Liver trouble
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Stomach pain
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Poor appetite
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Vomit blood
Skin			
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	itching

O	F	C	
☐	☐	☐	Skin rash
☐	☐	☐	Varicose veins
Genito-Urinary			
☐	☐	☐	Bed wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Loss control urine
☐	☐	☐	Kidney infection
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
☐	☐	☐	Smell of urine
Pain or Numbness in:			
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Ankles
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Sciatica
☐	☐	☐	Swollen joints
For Women Only			
☐	☐	☐	Cramps
☐	☐	☐	Heavy flow
☐	☐	☐	Light flow
☐	☐	☐	Irregular cycle
☐	☐	☐	Painful cycle
☐	☐	☐	Discharge
☐	☐	☐	Sore breasts

Menopausal: ☐ Yes ☐ No

Last Menstruation Date: _____

Pregnant: ☐ Yes ☐ No

Due Date: _____

HABITS OF LIFESTYLE

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

Exercise Indoor Activities: _____

Exercise Outdoor Activities: _____

Rate your sleep hours per night: ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12+

Do you wake rested? ☐ Yes ☐ No

Rate your appetite: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Rate your diet: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Do you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner

Do you eat per day: ☐ 1 meal ☐ 2 meals ☐ 3 Meals ☐ 4 meals ☐ More than 4 Meals

Do you take vitamins and minerals? ☐Yes ☐No

If Yes, please list: _____

Do you take any recreational drugs? ☐Yes ☐No

If so, what? _____

Have you ever been knocked unconscious: ☐ Yes ☐ No ☐ Don't Know

If so, for how long? _____

REASON FOR ASSESSMENT

Please describe in your own words what concerns you have. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific question do you have that you hope an evaluation will answer?

SIGNATURE _____ Date:___/_____/_____

Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip/Postal Code

Home Telephone ( ) _____ Work Phone ( ) _____ Cell # ( ) _____

Preferred contact number(s) _____

Email Address: _____ Male ____ Female _____ Birthdate _____

Occupation/Employer's Name and address _____

Single ____ Married ____ Divorced ____ Widowed ____ Your Social Security # (optional): _____

No. of children: _____ Spouse's Occupation/Employer: _____

Reason for consulting our office? _____

Who may we "Thank" for referring you to our office? _____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a Chiropractic office specializing in Holistic Family Care, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Often the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS	YES	NO	UNSURE		YES	NO	UNSURE
Did you have any childhood illnesses?	___	___	___	Did you take/use any drugs?	___	___	___
Did you have any serious falls as a child?	___	___	___	Did you have any surgery?	___	___	___
Did you play youth sports?	___	___	___	Were you vaccinated?	___	___	___
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)					___	___	___
Were you involved in any car accidents as a child?					___	___	___
Was there any prolonged use of medicine such as antibiotics or an inhaler?					___	___	___
Did you suffer any other traumas? (physical or emotional)					___	___	___
As a child, were you under regular chiropractic care?					___	___	___
Was your childhood a happy one?					___	___	___

COMMENTS: _____

_____

ADULT – (18 TO PRESENT)	YES	NO
Do/did you smoke?	___	___
Do/did you drink alcohol?	___	___
Do/did you play any adult sports?	___	___
Do/did you participate in extreme sports?	___	___

On a scale 0-10 describe your stress:

level (0=none/10=extreme)

Occupational_____ Personal _____

On a scale of Poor, Good or Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

WHAT BROUGHT YOU TO OUR OFFICE?

Chiropractic Wellness Care: _____
Network Spinal Analysis (NSA), Somato Respiratory Integration (SRI) and ReOrganizational Healing (ROH) Education

Specific Concerns: _____
Please describe any concern(s) including symptom areas and the affect it has had on your life and your family.

_____
_____

If you are experiencing pain, is it
Sharp___ Dull___ Achy___ Comes & Goes___ Travels/Moves___ Changes___ Constant__ Unbearable___
Since the problem started, is it About the same___ Getting Better___ Getting Worse___
What makes it worse: _____
Is it interfering with: Work___ Sleep___ Walking ___ Sitting___ Hobbies___ Leisure___ Life___
Other Doctors seen for this concern (please list)
Chiropractor _____
Medical Doctor _____
Other _____

Were X-Rays taken? _____ If not and if medically necessary, would you be opposed to having X-Rays taken? _____

Please check all symptoms you have ever had, even if they do not seem related to your current concern(s):

___ Headaches	___ Sensitive Eyes	___ Irritability	___ Diarrhea
___ Pins & Needles in Arms	___ Fainting	___ Fever	___ Constipation
___ Neck Pain	___ Ringing in Ears	___ Loss of Balance	___ Pins & Needles in Legs
___ Numbness in Fingers	___ Loss of Taste	___ Nervousness	___ Numbness in Toes
___ Fatigue	___ Buzzing in Ears	___ Upset Stomach	___ Menstrual Pain
___ Sleeping Problems	___ Dizziness	___ Tension	___ Menstrual Irregularity
___ Cold Hands	___ Cold Sweats	___ Hot Flashes	___ Back Pain
___ Stiff Neck	___ Mood Swings	___ Heartburn	___ Problem Urinating
___ Loss of Smell	___ Depression	___ Ulcers	___ Cold Feet

List medications, duration, and reason for taking: _____
_____

Family Health Profile:
As a Holistic Family Care office, we are also interested in the well-being of your family and loved ones, including their health history. Please list below any health conditions/concerns or poor lifestyle choices for your:

Children _____
Spouse _____
Mother _____
Father _____
Siblings _____
Others _____

Your Lifestyle:
Do you drink water: YES___ NO___ How much:_____ Bottled:____ Filtered:_____
Do you belong to a health club:_____ Exercise on your own:_____ No Exercise:_____
Do you consume vitamins, minerals or supplements: YES___ NO___
Please list:_____
_____

Are you interested in receiving nutritional consult? _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____
Signature Date

Dr. Tammy M. Kaminski * Cedarcrest Chiropractic * 616 Bloomfield Ave., Ste. 3C W. Caldwell NJ 07006 * (973) 228-6624

THE STRESS TEST

Name: _____ Date: _____ Chart #: _____

The human body is designed to be healthy. Throughout life, events occur which suppress &/or damage your health expression and your body's ability to adapt. The information on this form will help uncover layers of damage, primarily to your nervous system, which have resulted in less than optimum health.

Please circle when you experienced these stresses: C (child), T (teenager), A (adult), or N (not at all).

PHYSICAL STRESS:					EXPLAIN
Birth Traumas (as a mother or child)	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on your wallet for years	C	T	A	N	_____
Sleeping Position Stomach	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Book bag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for Many Hours	C	T	A	N	_____
Continuous Hours Sitting/Standing	C	T	A	N	_____
Bone Fracture	C	T	A	N	_____
Surgery	C	T	A	N	_____
EMOTIONAL STRESS:					
Relationships	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Money	C	T	A	N	_____
Fast-Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____
CHEMICAL STRESS:					
Environment (i.e. pollution)	C	T	A	N	_____
Smoker Amount?	C	T	A	N	_____
Second-hand Smoke	C	T	A	N	_____
Poor Diet, Fast Food, Soda	C	T	A	N	_____
Caffeine Amount?	C	T	A	N	_____
Excessive Sugar	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over-The-Counter Drugs (ie Tyenol/Mortin)	C	T	A	N	_____

What do you feel is your primary stress? _____

Would you consider your life to be in order at this time? _____

Have you undergone any great change in the last year? _____

Are there any significant fears present in your life? _____

Are you satisfied with your job/relationships/achievement of goals? _____

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