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

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

PEDIATRIC HISTORY FORM

It is a pleasure to welcome you to our Family Wellness office. To best serve your family, please complete the following information.

Patient Name: _____ #:_____ Date: _____

Address: _____

Home Phone: _____ Work #: _____ Cell #:_____

Sex: _____ Weight: _____ Height: _____ Birth Date: _____

Names of Parents/Guardians: _____ Email: _____

Referred By: _____ SS # (optional): _____

Reason For Contacting Us: _____

Other doctors seen for this condition: N _____ Y_____ Doctors□names and prior treatments:_____

_____

Other health concerns: _____

Check any of the following conditions your child has experienced:

___ Ear Infections	___ Scoliosis	___ Seizures	___ Chronic Colds	___ Headaches
___ Asthma/Allergies	___ Digestive Problems	___ ADHD/ADD	___ Recurring Fevers	___ Growing/Back Pains
___ Colic	___ Bed Wedding	___ Car Accident	___ Temper Tantrums	___ Other _____

Family history: _____

Previous chiropractor: _____ Date of last visit: _____

Reason: _____

Name of pediatrician: _____ Date of last visit: _____

Reason: _____

Are you satisfied with their care of your child? N _____ Y_____ Are your questions being answered? N____ Y____

Number of doses of antibiotics your child has taken: Past six months: _____ Total during his/her lifetime: _____

Number of doses of other prescription medications your child has taken:
During the past six months: _____ Total during his/her lifetime: _____ List:_____

Number of doses of over-the-counter medications (OTC) your child has taken:
During the past six months: _____ Total during his/her lifetime:_____

Vaccination History: _____

Adverse Vaccine Reactions: _____

Prenatal History:

Name of obstetrician/midwife: _____

Complications during pregnancy? N_____ Y_____ List: _____

Ultrasounds during pregnancy? N _____ Y_____ Number: _____

Medications during pregnancy/delivery? N _____ Y_____ List: _____

Cigarette/alcohol use during Pregnancy? N _____ Y_____

Locations of birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Caesarian Section, Emergency or Planned?

Complications during delivery? N _____ Y_____ List: _____

Genetic disorders or disabilities: N _____ Y_____ List: _____

Birth weight: _____ Birth length: _____ APGAR scores: _____ , _____

Feeding History:

Breast fed: N _____ Y_____ How long: _____

Formula fed: N _____ Y_____ How long: _____ Type: _____

Introduction to solids at: _____ Months Cow's milk at _____ Months

Food/juice allergies or intolerances: N _____ Y_____ List: _____

_____

Developmental History:

Your child's spine is most vulnerable to stress and should regularly be checked by a Doctor of Chiropractic for prevention and early detection of spinal cord tension, vertebral subluxation and spinal nerve interference. At what age was your child able to:

Sucking Reflex _____ Respond to Visual Stimuli _____ Sit Up _____ Stand Alone _____
Respond to Sound _____ Hold Head Up _____ Cross Crawl _____ Walk Alone _____

According to the Nation Safety Council, approximately 50% of children fall head first from a high place during their first year of life. (i.e. a bed, changing table, down stairs, etc.) Was this the case with your child? N_____ Y_____
Please explain: _____

_____

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? N _____ Y_____ List: _____

_____

Has your child ever been involved in a car accident? N _____ Y_____ List:_____

Other traumas not described above? N _____Y_____ List: _____

Has your child been seen on an emergency basis? N _____ Y_____ List:_____

Prior surgery: N _____ Y_____ List: _____

Menarche: N _____ Y_____ Age: _____

Childhood Diseases:

Chicken Pox	N / Y	Age _____	Rubeola	N / Y	Age _____	Mumps	N / Y	Age _____
Rubella	N / Y	Age _____	Whooping Cough	N / Y	Age _____	Other	N / Y	Age _____

We are here to serve you and your family.
Questions regarding the health and wellbeing of your child are encouraged.
Your participation is vital in determining positive results and achieving our goals.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Witnessed: _____ Date: _____

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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