THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at **Family Chiropractic of Merrimack and Wellness Center LLC,** we may use or disclose personal and health related information about you in the following ways:

**Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.*
**Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services and sending claims on your behalf.*
**Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, inform you of health related meetings, workshops or products or and other information that may be of interest to you.*

Should we need to reach you for reminders of appointments or follow ups from the doctor or other staff for any reason and you are not at home or pick up to receive an appointment a message may be left on your answering machine or voice mail. Text message is avail to opt into for reminders. Further**,** you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this

notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Timothy Troy, DC, Family Chiropractic of Merrimack LLC. If you would like further information about our privacy policies and practices please contact: Timothy Troy, DC.

This office utilizes an **"open-adjusting"** environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information.

It is our desire for our staff to use your first name, photograph and/or radiograph with this as your permission on our face book announcement boards or other marketing, Referral Boards, X-Ray view boxes, family picture wall, Newsletter and In-Office promotions.

It is our desire for our staff to use your name and/or signature on our sign-in sheets in order to verify your office or workshop visits per request from other health care professionals or for any proof of care in the office for allowable businesses such as Flex Dollars, disability, or employer requests.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality Chiropractic care.

This notice is effective as of January 1, 2018. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice to be found on the form in my paper file.

FAMILY CHIROPRACTIC OF MERRIMACK AND WELLNESS CENTER LLC

36 Baboosic Lake Road Merrimack NH 03103
603-262-9200

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
HIPPA (Health Insurance Privacy and Portability Act.)

I have received a copy of the HIPPA notice for this office's privacy practices.

Printed Name:____

Signature:____ **DATE:** ____________

Should you be under 18years of age a Parent/ or Legal Guardian must sign this form for your Hippa Recognition.

Printed Name of Minor:____

Printed Name of Person Signing & Relationship:________________________________

Signature of Parent or Legal Guardian:_____________________________**Date:**________

For those of legal adult age of 18 or over: I hereby give my permission to discuss any and all aspects of my chiropractic treatment to the following individuals listed below, including but not limited to changes in my schedule, payments made by others on my behalf, insurance or changes in insurance, or changes with my care plan in the office, as well as having them obtain important information should I not be available.

- Spouse: ____
- Significant Other:____
- Mother: ____
- Father: ____
- Specific Other:____

*Should you want your records transferred to another health care professional please list the office with as much information as you can. If throughout your care you would like your records shared you will be asked to sign another release for that specific office as well.

Name of Office:____

Doctor or Practitioners Name:____

Phone Number:____

Welcome to Wellness!

36 Baboosic Lake Road
Merrimack, NH 03054
603*262*9200
www.healthymerrimack.com

Family Chiropractic of Merrimack; Adult Health Questionnaire

Name:____

Prefer to be called:__________________

Home Phone: ____

Cell Phone:_____________________________________

Address:____

City, State, Zip:______________________________________

Date of Birth:____________

Male / Female   Age:____

SS#:______-______-__________**(for insurance purposes)**

Email:________________________

Occupation(s):________________________________

Employer:______________________________

Employer's Phone#_________________

Employer's Address:________________________________

Do you have insurance? Yes / No

Primary Policy Holder's name and Date of Birth:_____________________

Marital Status: M   W   D   S

Spouse or Significant Others Name:________________________________

No# of Children:______________

Name(s) and age(s) of Children:______________________________________

____

1. Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office?____

2. Science tells us your spine should be cared for regularly. How often do you get adjusted by a chiropractor?

Frequently/only when you hurt/1 x monthly/never

3. When was your last complete spinal examination including x-rays?_________________
☐ Never

4. Do you know if you have a spinal curvature, spinal arthritis, or inherited spinal problem?

☐ Yes ☐ No

5. Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck?☐ Yes ☐ No

6. If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back? ☐ Yes ☐ No

7. Poor posture leads to poor health and early death. How would you rate your posture?

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

8. Stress will cause you to accelerate spinal damage. Rate your stress level over the last 3 months.

Calm/Relaxed 1 2 3 4 5 6 7 8 9 10 Very tense/Tight

9. Please circle or list any health symptoms or health complaints you are experiencing.

Neck pain L/R	**Arm pain/Numbness L/R**	**Asthma**	**Thyroid**
Leg pain L/R	**Heart_____________**	**Cancer**	**Sinus**
Mid-back pain L/R	**Headaches/Migraines**	**Constipation**	**Low Energy**
Lower-back pain L/R	**Diabetes I/II**	**Menstrual pain**	**Anxiety**
Allergies:________________	**Depression**	**Other: _________________**	

10. Prescription medications cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?
(Use back if necessary or we can gladly take a copy of a list that you may have)

1.______________________2.__________________________3.__________________________

11. Please list any surgeries you have had (use back if necessary). _________________________________
____

12. Daily trauma, auto accident(s), and work injuries can cause serious spinal problems.
When was your most recent :
Injury at Home?_______________
Car Accident?_________________
Slip or fall?___________________

13. (Females only) Spinal health is vitally important to ensure a healthy pregnancy. Is there a chance you are pregnant? ☐ Yes ☐ No

14. Do you smoke? ☐ Yes ☐ No Drink Coffee? ☐ Yes ☐ No

15. Improper sleeping positions can cause spinal damage, what sleeping position do you sleep in:
☐ Back ☐ Stomach ☐ R Side ☐ L Side

16. Exercise level: Never 1 2 3 4 5 6 7 8 9 10 6x @wk

17. Are you? ☐ Right Handed ☐ Left Handed ☐ Both Handed

18. Please list vitamins/supplements you take (use back if necessary):_____________________________
____

19. If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely? ☐ Yes ☐ No

The above information is true and accurate to the best of my knowledge.

Patient Signature (Parent/Guardian):_____________________________Date:____________________

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

____

Print Name **Signature** **Date**

Consent to evaluate and adjust a minor child

I, ____________________being the parent or legal guardian of ___________________have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:__________________________

____

Signature **Date**

36 Baboosic Lake Rd, Merrimack, NH 03054
Dr. Timothy Troy D.C.
603-262-9200
www.healthymerrimack.com

Welcome To Wellness!

36 Baboosic Lake Road
Merrimack, NH 03054
603*262*9200

Family Chiropractic of Merrimack; Child Health Questionnaire

Name____________________________________ Age____________________
D.O.B.______________________ Address___________________________________
City _________________________ State _____________ Zip Code_______________
Name(s) and age(s) of siblings____
Parent(s)/Guardian (s) Name(s)____
Parent(s)/Guardian(s) occupation(s) _______________________________________
Parent (s)/Guardian (s) Phone (Home) ___________ (Work/Cell) _____________
Who may we thank for referring you and your child to **Family Chiropractic of Merrimack and Wellness Center**? ____
Has your child ever benefited from chiropractic care? O Yes O No
When was their last visit? _______________________________
Reason for today's Chiropractic evaluation: ____
____
Have you consulted any other health care practitioners for this reason? ________
If Yes, Who? ____
What are your goals for your child in this office? _________________ ____________
____

I hereby authorize and consent to the chiropractic evaluation and care of my child.
Parent/Guardian Signature ________________________Date____________

Health History

Many of the health challenges that people will face originate from stressors experienced during developmental years (including gestation and birth). These stressors (traumas) may be emotional, physical, or chemical. **This health record is designed to help us understand the stressors your child might have already experienced, and to maximize your child's health and wellness.**

The Pregnancy Process

During the pregnancy process, did the mom:
O Take medications? Type ____
O Smoke or consume alcohol or drugs? ___________________________________
O Experience any illness? Type ____
O Undergo a lot of stress? ____
O Receive other radiation? ___________ How many? _________

The Birthing Process

Birthplace: **O** Home **O** Hospital **O** Birthing Center
Type of Birth: **O** Vaginal **O** C-Section **O** Cephalic (head first) **O** Breech (feet first) **O** Occiput Posterior (facing forward)
Procedures: **O** Forceps **O** Vacuum Extraction
Birth Assistants: **O** M.D. **O** **M**idwife **O** Doula
Did the person assisting the delivery twist or pull the baby during the delivery? **O**Yes **O**No
How long did labor & delivery last? ________ hours
What was the mother's position during labor? **O** Back **O** Side
O Sitting **O** Standing **O** Other______________________
Did the mother have an episiotomy? **O** Yes **O** No
Was labor chemically induced? **O** Yes **O** No
What was the child's gestational age at birth? _______________________________
Were any drugs administered during the labor process (IV, epidural)?
O Yes **O** No
Was your child subjected to any of the following? **O** Silver Nitrate eye drops
O Incubation (how long?) ______________ **O** Vitamin K injection
O Hepatitis injection **O** Separation from mother (how long?) __________________

Vaccinations

Have you chosen to vaccinate your child? **O** Yes **O** No
If yes, check all vaccinations received: **O** DPT **O** MMR **O** Polio
O Chicken Pox **O** Hepatitis **O** Flu **O** Other___________________________
Describe any reactions to the vaccine(s): ____
____
____
____
____
____
____

Growth and Development

At what age did your child?
Follow an object____________________ Respond to sound____________
Hold up head______________________ Vocalize_____________________
Sit unassisted_______________________ Teethe______________________
Crawl______________________________ Walk_________________________

O vision problems **O** pink eye **O** constipation
O headaches **O** ear problems **O** asthma
O sleeping difficulty **O** tubes in the ears **O** colic
O irritability **O** attention problems **O** hyperactivity
O skin problems **O** frequent colds **O** bedwetting
O breathing problems **O** digestive problems **O** allergies (list) _____________
____
O other ____
Notes:____
____
____
Is your child accident-prone? ____
Average number of hours your child watches television, plays on the computer, or plays electronic games each week, if any? _________________________________
Do you feel that your child's social and emotional development is normal for their age? (Please explain) ____
Does your child have any night terrors, sleep walking, difficulty sleeping? **O** No **O** Yes
If yes please explain: ____
Has your child:
Been hospitalized/surgery? **O** No **O** Yes: ______________________________
Had a severe fall? **O** No **O** Yes: ____
Been in a car accident? **O** No **O** Yes: ____________________________________
Has your child had traumas resulting in bruises, fractures, or stitches? _________________
____
Any sports participation? (Please list)
____
Approximate hours of playtime each week _________________________________
Is a school backpack used? (Heavy or Light) _________________________________
Has your child ever taken antibiotics? **O** Yes **O** No
If yes, how often & why?____
Has your child ever taken or currently taking any other medications (OTC or prescription)?
O Yes **O** No If yes, explain: ____
____
Was your child breast fed? **O** Yes **O** No
If yes, for how long?_________________________________
Does your child consume?
O fruits **O** vegetables **O** lean meats and fish
O nuts **O** omega 3 fatty acid supplement **O** Probiotics
O caffeine **O** soda **O** sugar **O** artificial sweetener **O** fast food
O processed foods **O** water