



# FAMILY

CHIROPRACTIC AND NUTRITION

1641 Venture Dr., Mount Vernon, Ohio 43050  
P: 740-397-1212 F: 740-397-4301

## MVNU NEW PATIENT

### HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient’s rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes \_\_\_\_ No \_\_\_\_

May we leave a message on your answering machine or your cell phone? Yes \_\_\_\_ No \_\_\_\_

May we discuss your medical condition with any member of your family? Yes \_\_\_\_ No \_\_\_\_

If Yes, please name those members allowed: \_\_\_\_\_

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This consent was signed by (Please Print Name): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## **Informed Consent to Treat**

I hereby give Mark Boynton, DC or other licensed Doctor of Chiropractic who now or in the future work at the clinic(s) or office(s) listed below consent to the performance of nutritional/functional medicine counseling, chiropractic adjustments, diagnostic x-rays on me, family members or the patient named below for whom I'm legally responsible, and other chiropractic procedures. These may include various modes of physical therapy, massage therapy, muscle stimulation, ultrasound, stretching or vibration therapy.

I have had an opportunity to discuss my health care needs, nature and purpose of chiropractic adjustments, other procedures and counseling with Mark Boynton, DC and/or with the other office or clinic personnel. I understand that the results are not guaranteed.

I understand in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely upon the doctor to exercise judgement, based upon the facts then known to him or her, in providing treatment which the doctor feels is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Financial Policy

Thank you for choosing Family Chiropractic and Nutrition, LLC. I'm committed to providing you with the best care possible. This goal is best achieved by letting you know in advance of our financial policy, which is an agreement between the doctors of the practice and the patient. Your clear understanding of the financial policy agreement is important to our professional relationship. This is a unique opportunity for you as a student at MVNU to obtain Chiropractic care right here on campus. I'm thrilled to be able to provide this care to you as a convenience and as a chance to give back to my alma mater. Payment is required at the time of service, unless other arrangements have been made. Payment options will include cash, check or credit card. I will not be offering any payments or agreements through your private medical insurance. If you would like to use your medical insurance I would be happy to care for you out of the main office at 1641 Venture Dr. Suite C, Mt. Vernon, Ohio 43050.

## Cancellation Policy

I understand the rigors of schooling all too well and appreciate that at times things come up out of the blue. I only ask that if you can't make your scheduled appointment, you contact the MVNU clinic via [nurse@mvnu.edu](mailto:nurse@mvnu.edu) or 740-507-0275 to inform them of your cancellation, so I can have the opportunity to serve as many students as possible during my short window on campus. Please note, if you continue to cancel your appointments, I may have to dissolve our professional relationship.

## New Patient Form

Patient's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Age: \_\_\_\_\_ Gender at birth: \_\_\_ M \_\_\_ F Marital status: Y / N

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone/Home Phone: \_\_\_\_\_ Wireless Carrier: \_\_\_\_\_

Email: \_\_\_\_\_

Highest Education Level: High School \_\_\_ Under-Grad Degree \_\_\_ Post-Grad Degree \_\_\_

Genetic Background: Place a check mark next to your selection(s). African American \_\_\_ Asian \_\_\_

Caucasian \_\_\_ Hispanic \_\_\_ Mediterranean \_\_\_ Native American \_\_\_ Northern European \_\_\_

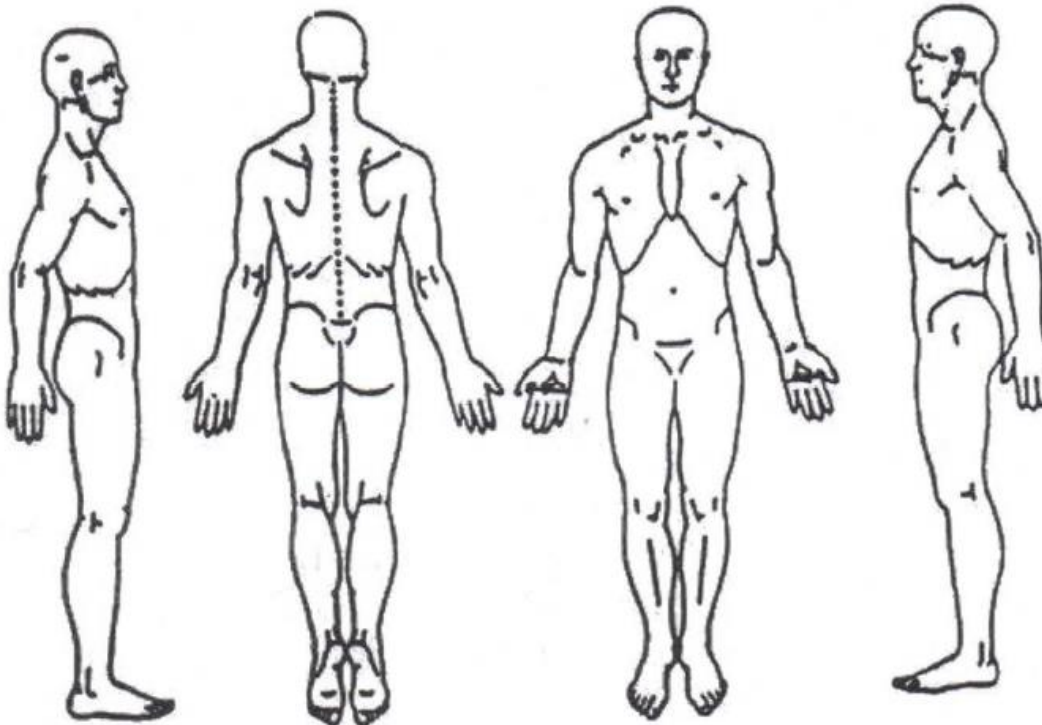
Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_

## Current and Ongoing Complaints

Problem/Location	Date of onset	Frequency	Treatment Approach	Pain Type	Severity 0-10
ie: low back		Constant	Chiropractic, meds	Sharp/dull	

Please circle the corresponding painful areas below:



Right

Posterior

Anterior

Left

What seems to make you feel better? \_\_\_\_\_

What seems to make you feel worse (certain movements, weather changes, etc.)?  
\_\_\_\_\_

If you could make only one improvement in your health, what would it be? \_\_\_\_\_  
\_\_\_\_\_

Is your pain due to an injury? \_\_\_\_ Yes \_\_\_\_ No If yes, please describe the injury and the date it occurred: \_\_\_\_\_  
\_\_\_\_\_

If no, please describe how long you have had this pain and what you believe it is caused by:  
\_\_\_\_\_  
\_\_\_\_\_

Please rate your overall health: Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

Please rate your energy levels: Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

Height (feet/inches): \_\_\_\_\_ Current weight: \_\_\_\_\_

Desired weight: \_\_\_\_\_ Highest adult weight: \_\_\_\_\_

**Please list all medications and supplements you are currently taking**

Medication/supplement	Dose if known	Frequency	Length of time taken	Reason for taken

## Medical History

**Current or past medical conditions** (list date of diagnosis or onset): \_\_\_ None

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**Accidents or Major Trauma / Injuries** (list month and year): \_\_\_ None

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**Surgeries/Hospitalizations** (list month, year, reason) including cosmetic surgery: \_\_\_ None

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## Family Medical History

List any major illnesses for each family member. If deceased, give cause of death and age at death:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Maternal grandparents: \_\_\_\_\_

Paternal grandparents: \_\_\_\_\_

Brothers/sisters: \_\_\_\_\_

Please list any other complaints or information not previously mentioned: \_\_\_\_\_

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## Lifestyle History

Average hours of sleep per night? \_\_\_\_\_ Do you exercise regularly? \_\_\_\_\_

Current exercise program? \_\_\_\_\_

Are you extra tired after exercising? Yes No Do you sweat when exercising? Yes No

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you handle stress well? Yes No

Are you happy overall? Yes No

## Nutritional History

Do you currently follow any particular diet or nutritional program? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_Gluten-Free \_\_\_\_Low-Carb \_\_\_\_Dairy-Free \_\_\_\_Vegetarian \_\_\_\_Blood Type \_\_\_\_Other

How many servings of fruits and vegetables do you eat per day? \_\_\_\_\_

How much water do you drink daily? \_\_\_\_\_

Do you have symptoms immediately after eating? \_\_\_\_\_ Yes \_\_\_\_\_ No

Specify symptoms and any associated foods: \_\_\_\_\_

When you miss meals or go without food for extended periods of time, do you feel weak, dizzy, hangry, irritable (explain)? \_\_\_\_\_

Frequency of bowel movements (daily or weekly)? \_\_\_\_\_

Please list anything not covered on this form that you would like us to discuss: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Symptoms Review

Never    Past    Current


- Aches/Pains, sensitive to touch
- General Weakness
- Cold hands and feet
- Easily fatigued or exhausted
- Difficulty falling/staying asleep
- Nightmares
- No dream recall
- Daytime sleepiness
- Sleep less than 8 hours a night
- Need for caffeine to really wakeup
- Feel unrefreshed upon waking
- Worn out with little effort
- Feel worse standing, legs heavy
- Considered sickly or in poor health
- Hands tremble slightly for no reason
- Balance problems

Never    Past    Current


### Lower Back

- Sciatica pain radiating down leg(s)
- Bulging or herniated disc
- Traumas or fractures
- Numbness or tingling in legs
- Foot Drop
- Any previous or ongoing diagnosis

### Neck


- Stiffness
- Lumps/swelling
- Neck glands swell
- Goiter

### Females only


- Are your periods every 28
- Are they painful
- Are you irritable
- Difficulty getting pregnant

