WELCOME TO OUR OFFICE! IT IS WELL KNOWN THAT FAMILIES WHO MAINTAIN STRONG HEALTHY, WELL-ALIGNED SPINES HAVE MUCH IMPROVED HEALTH. PEOPLE WHOSE SPINES ARE NOT KEPT IN PROPER ALIGNMENT ARE MUCH MORE LIKELY TO DEVELOP HEALTH DISORDERS LATER IN LIFE.

Name____ Date _____________________

Address ____ City ___________________

State_______ Zip Code__________________ Social Security #_____________________________

Home Phone _____________________________ Work Phone ______________________________

Cell Phone ______________________________ Cell Carrier _________________________________

Which phone # and time is best to reach you? Home / Work / Cell Time(s)____________________

Age _______ Birth Date___________/___________/___________ Sex: ☐ MALE ☐ FEMALE

Your Occupation ____

Employer____

Email ____ Marital Status: ☐S ☐M ☐D ☐W ☐SEP

Number of Children & Ages ____

Spouse's Name _____________________________ Occupation ___________________________

Employer_______________________ Do you have health insurance? ☐ YES ☐ NO

Insurance company name: ____

Any other form of payment (*Ex: flexible spending account, HSA, etc.*):__________________________

Most patients are referred to our office by a caring family member or friend.

What made you decide to visit our office?

Friend/Family Member Name ____

☐ INTERNET ☐ YELLOW PAGES ☐ SIGN ☐ PRESENTATION ☐ E-MAIL ☐ OTHER _______________________

1) IS THIS VISIT RELATED TO A:

☐ Work Related Injury/Symptoms ☐ Non-Injury Pain/Symptoms ☐ Check-up Only
☐ Sport or Recreational Injury ☐ Motor Vehicle Accident ☐ Other (Describe):

REASON FOR CARE:____

2. Indication Where You Are Having Your Problems:

❑ Headache
❑ Neck pain
❑ Shoulder pain
❑ Pain between shoulders
❑ Elbow pain
❑ Sprain / Strain
❑ Numbness or tingling in arm or leg
❑ **NO Pain/Discomfort**
❑ Hip pain
❑ Knee pain
❑ Ankle / foot pain
❑ Low back pain
❑ Broken bones
❑ Upper back pain
❑ Wrist hand pain
❑ Stiffness/Tightness
❑ Other: ____

3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb □ Agonizing □ Stinging
□ Dull □ Tingly □ Throbbing □ Unbearable
□ Diffuse □ Sharp with motion □ Cramping □ Tender
□ Achy □ Shooting with motion □ Crushing □ Prickling
□ Burning □ Stabbing with motion □ Nagging □ Annoying
□ Shooting □ Electric like with motion
□ Stiff □ Other:____

5. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

(Circle a number) 0 1 2 3 4 5 6 7 8 9 10

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? ______________________________

11. How do you think your problem began? ____

12. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

13. What aggravates your problem? ____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: Height_________________________ **Weight** _________________________________

16. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

18. What Makes your symptoms worse?

- □ Always there
- □ Bends
- □ Bicycles
- □ Breathes Deeply
- □ Climbs Stairs
- □ Coughs
- □ Drives
- □ Goes Down Stairs
- □ Golfs
- □ Paints
- □ Picking up Child
- □ Runs
- □ Sits
- □ Sleeps
- □ Sneezes
- □ Prolonged Standing
- □ Stands up
- □ Is under Stress
- □ Uses a Telephone
- □ Plays Tennis
- □ Throws a ball
- □ Travels
- □ Turning over in Bed
- □ Walks
- □ Notices a Weather Change
- □ Works
- □ Works at a computer
- □ Working out

Other: ________________________

Other: ________________________

19. What provides Relief?

- □ Adjustments
- □ Analgesic Cream
- □ Bending Forward
- □ Exercising
- □ Heat
- □ Ice
- □ Relaxation Tapes
- □ Lying Face Down
- □ Lying on Back with knees Bent
- □ Lying on your Side
- □ Massage
- □ Muscle Relaxers
- □ NSAIDS
- □ Pilates
- □ Prescription Pain Meds
- □ Resting
- □ Standing
- □ Stretching
- □ Swimming
- □ T.E.N.S. Unit
- □ Tylenol
- □ Walking
- □ Warm Bath
- □ Wearing Orthotics
- □ Yoga

Other: ___________________________________

Other: ___________________________________

20. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

21. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	**Jaw Pain**	□	□	**High Blood Pressure**	□	□	**Diabetes**
□	□	**Joint Pain/Stiffness**	□	□	**Heart Attack**	□	□	**Excessive Thirst**
□	□	**Arthritis**	□	□	**Chest Pains**	□	□	**Frequent Urination**
□	□	**Cancer**	□	□	**Stroke**	□	□	**Smoking/Tobacco Use**
□	□	**Tumor**	□	□	**Angina**	□	□	**Drug/Alcohol Dependence**
□	□	**Asthma**	□	□	**Kidney Stones**	□	□	**Allergies**
□	□	**Chronic Sinusitis**	□	□	**Kidney Disorders**	□	□	**Depression**
□	□	**Dizziness**	□	□	**Bladder Infection**	□	□	**Systemic Lupus**
□	□	**Loss of Appetite**	□	□	**Painful Urination**	□	□	**Epilepsy**
□	□	**Abdominal Pain**	□	□	**Loss of Bladder Control**	□	□	**Dermatitis/Eczema/Rash**
□	□	**Ulcer**	□	□	**Prostate Problems**	□	□	**HIV/AIDS**
□	□	**Hepatitis**	□	□	**General Fatigue**			***FOR FEMALES ONLY***
□	□	**Visual Disturbances**	□	□	**Abnormal Weight Gain/Loss**	□	□	***Birth Control Pills***
			□	□	**Muscular Incoordination**	□	□	***Hormone Replacement***
						□	□	***Pregnancy***
□	□	**Other**______________________________________						

22. Prescription Medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

____

23. List all of the over-the-counter medications you are currently taking:

____

24. List all surgical procedures you have had:____

25. What activities do you do at work?

- □ **Sit:** □ Most of the day □ Half the day □ A little of the day
- □ **Stand:** □ Most of the day □ Half the day □ A little of the day
- □ **Computer work:** □ Most of the day □ Half the day □ A little of the day
- □ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

26. What activities do you do outside of work?____

27. Have you ever been hospitalized? □ No □ Yes If yes, why ______________________________

28. Have you had significant past trauma? □ YES □ NO What Happened: ______________________

Were You Ever in An Auto Accident? □ YES □ NO Date of Incident ____________________

29. Anything else pertinent to your visit today?______________________________________

THE SOURCE OF HEALTH

Authorization and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of Health Portability and Accountability (HIPPA) is available here:
http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposerule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to payor(s) named by the patient for the purpose of payment, this office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at anytime and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to these restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care of services.
4. This office is committed to protecting your PHI and meeting its HIPPA obligations: staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Consent to Professional Treatment

This patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen(18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for treatment of the child as provided herein. The patient may refuse at any time.

Consent to perform and interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third-party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Financial Obligation and Appointment Policy

The patient accepts full responsibility for services rendered by this office. This office reserves the right to charge fair market value for missed appointments or canceled appointments without advance notification required by this office. Payment in full is required for all services at the time of the visit, unless alternative arrangements have been agreed in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collections of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician. The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by the patient to the practice for future and current charges, when incurred.

Additional Understanding and consent of services:

NET: The NET practitioner uses muscle testing, body reflex points, and semantic reactions (physiological reactions to memories or words) to assist and guide you to recall the specific negative emotion and when it first occurred. This engages a specific neuro-emotional pattern, much as a computer operator engages a specific program on a computer screen. While you mentally hold the emotional memory, the practitioner can make the physical correction associated with it. NET treatment is not a substitute for psychological or psychiatric therapy. Patients who show a possible need for psychotherapy are referred to psychological or psychiatric professionals for evaluation and/or treatment.

NET is not used to fix emotions. NET is about fixing the subluxation and not the emotions. In fact, emotions do not need to be fixed. Darwin expounded on emotions in a non-psychoLOGICAL way, supporting the concept that emotions are normally a healthy phenomena, found in humans and animals. In an unhealthy organism, however, emotions can cause psychosomatic and somatopsychic problems (see NECs below). This is not a "mental" condition, but rather a whole mind/body relational problem. NET is not counseling. The term "emotional" can also conjure up images of clinical counseling, which NET, in fact, does NOT employ. Although counseling in chiropractic, osteopathic, acupuncture, etc., offices is legal in most (if not all) states in the USA, it is not used in the NET procedure.

Homeopathy: Homeopathy views health and illness in a holistic manner. In working with the whole person, homeopathy takes into consideration the mental/emotional situation and general well being of a person as well as specific physical symptoms. Homeopathy works by stimulating the body's own capacity to heal and exploring the fundamental causes of ill health. At times

with homeopathic treatment there can be a minor aggravation or worsening of some symptoms soon after taking a remedy as part of the general healing process. Homeopathy is not meant to diagnose illness, make recommendations involving pharmaceutical drugs or surgery, or handle medical emergencies.

Applied Kinesiology: A.K. is an interdisciplinary approach to health care, which draws together the core elements of the complementary therapies, creating a more unified approach to the diagnosis and treatment of functional illness. A.K. uses functional assessment measures such as posture and gait analysis, manual muscle testing as functional neurologic evaluation, range of motion, static palpation, and motion analysis. These assessments are used in conjunction with standard methods of diagnosis, such as clinical history, physical examination findings, laboratory tests, and instrumentation to develop a clinical impression of the unique physiologic condition of each patient including an impression of the patient's functional physiologic status. When appropriate, this clinical impression is used as a guide to the application of conservative physiologic therapeutics. It is extremely effective in discovering areas that are weak, overloaded or stressed, including the spine, joints, organs and even emotions. If you understand what it means to have stress affect you physically, or to have aches and pains cause you emotional distress, then you understand the importance or getting to the root cause of your problem. The Doctors and staff at the Source of Health are committed to uncovering these root causes and helping you to heal permanently versus having to come in repeatedly for the same issues.

I consent to the use or disclosure of my protected health information by the use of Applied Kinesiology and the Source of Health and associates/employees for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Applied Kinesiology and Source of Health and associates/employees. I understand that diagnosis or treatment of me by Applied Kinesiology and Source of Health and associates/employees may be conditioned upon my consent as evidenced by my signature on this document.

Essential Oils: The oils we use and provide are pure essential oils. The suggested remedial uses and other qualities have been obtained from lectures and books about essential oils, personal experiences, and from the successful experiences of others. Information and treatment contained herein is not provided in order to diagnose, prescribe or treat any disease, illness or injured condition of the body. Furthermore, neither the doctor or staff of this material nor any maker or distributor of essential oils assume responsibility for such use. Anyone suffering from any disease, illness or injury should consult with a physician or health care provider. Customers purchasing essential oils are assumed to have full knowledge of their use, properties, safety precautions, and dosages or be advised of proper use of essential oils by a qualified health professional.

I have reviewed, acknowledge, and understand the content of the Consent To Care, Authorization and Releases, and Additional Understanding and Consent of Services.

PRINTED PATIENT NAME ____________________________________ DATE ____________________

SIGNATURE ____

PRINTED NAME OF PARENT/GUARDIAN ____

SIGNATURE OF PARENT/GUARDIAN: ____

Consent To Care

I do hereby authorize the doctors of THE SOURCE OF HEALTH to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments or any other procedure, which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand that any sum of money paid under assignments by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, ____ have read, understand and hereby request chiropractic care based on the above agreement.

Date: ________________

Signature: ____

Signature of parent/guardian if patient is a minor: ____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, 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 may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Testimonials: I give “the Source of Health” permission to, use my testimonial with or without my name, photograph, and/or video testimonial: in ads, brochures, on the Web site, and in other promotions used to market their services, in the interest of telling others about the benefits of chiropractic.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open setting with other patients where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used if we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency. In addition we may occasionally video tape our front desk or open adjustment area for training purposes.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You nay revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an

authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

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.

You have the right to inspect and copy your 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, health operations or additional uses listed above in paragraph 8. 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 chiropractor is not required to agree to a restriction that you request. If your chiropractor 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. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

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 electronically.

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. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Constandinos Shizas, Chiropractor ((973)794-3762, fax: (973)794-3763, 1279 Route 46 East, Bldg A, Suite 3, Parsippany, NJ 07054

I have received a copy of this office's 2 page Notice of Privacy Practices and consent to the use and disclosure of protected health information by Constandinos Shizas, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. "You May Refuse To Sign This."

I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON October 1, 2006.

Printed Patient Name ______________________________________ Date ______________________________

Signature ____

Printed Name of Parent/Guardian ____

Signature of Parent/Guardian: ____