CHIROPRACTIC WORKS
James W. Cassillo D.C.

Name: _____Cell #_____Age_____Date_____

Address: _____

Home Phone_____Work Phone_____Male___Female___

Social Security#_____E-Mail Address_____Birthdate_____

Occupation/Employer's Name and address_____

Single___Married___Divorced___Widowed___Spouse's Name_____No. of children_____

Reason for consulting our office? _____

Who may we thank for referring you to our office? _____

YOUR HEALTH PROFILE

As a full spectrum Chiropractic office, 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. Most times 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 (PLEASE ANSWER YES, NO OR UNSURE)

Did you have any childhood illnesses?

Did you have any serious falls as a child?

Did you play youth sports?

As a child did you take/use any drugs?

As a child did you have any surgery?

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?

As a child was there any prolonged use of medicine such as antibiotics or an inhaler?

As a child did you suffer any other traumas? (physical or emotional)

Were you vaccinated?

As a child, were you under Chiropractic care?

Was your birth a c-section/ traumatic/complications?

Adult Years - 18 to present (PLEASE ANSWER YES OR NO)

Do/did you smoke?
Do/did you drink alcohol?
Have you been in any accidents?
Have you had any surgery?

Do/did you play adult sports?
Do/did you participate in extreme sports?
On a scale of 1 - 10 describe your stress level: (1 = none / 10 = extreme)
Occupational _____
Personal _____

On a scale of poor, good, excellent, describe your: Diet_____ Exercise_____
Sleep _____ General Health_____

****IF YOU HAVE NO SYMPTOMS OR COMPLAINTS, AND ARE HERE FOR WELLNESS SERVICES, PLEASE CHECK HERE_____ I WISH TO HAVE CHIROPRACTIC WELLNESS SERVICES' AND SKIP TO FAMILY HEALTH PROFILE. OTHERS NEED TO BRIEFLY DESCRIBE THE CHIEF AREA OF COMPLAINT, INCLUDING THE EFFECT IT HAS HAD ON YOUR LIFE.**

Chief Complaint _____
How did it start? _____
When did it start? _____
If you are experiencing pain, is it Sharp___Dull___Comes and goes___Travels___Constant___
Other_____
Since the problem started, it is: About the same___ Getting Better___ Getting Worse___
What makes it worse? _____
Does it interfere with: Work___Sleep___Walking___Sitting___Hobbies___Leisure___

Other Doctors seen for this problem (please list)
Chiropractor_____ Medical Doctor_____
Other_____
Any x-rays, MRI's, Diagnostic tests (when and where)_____
_____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

___Headaches	___Pins and needles in legs	___Fainting	___Neck pain
___Dizziness	___Buzzing in Ears	___Neck Stiff	___Nervousness
___Numbness in fingers	___Numbness in toes	___Diarrhea	___Tension
___Sleeping Problems	___Loss of Balance	___Loss of taste	___Hot Flashes
___Mood Swings	___Menstrual Pain	___Cold Sweats	___Cold hands
___Pins and needles in arms	___Loss of smell	___Back Pain	___Fever
___Ringing in ears	___Problem Urinating	___Fatigue	___Cold Feet
___Menstrual Irregularity	___Light bother eyes	___Depression	___Heartburn
___Knee pain	___Constipation	___Irritability	___Ulcers
___Chest Pain	___Bowel troubles	___High Blood Pressure	
___High Cholesterol	___Difficulty Breathing	___Shoulder Pain	
___Knee Pain	___Other _____		

FAMILY HEALTH PROFILE
At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your children, spouse, mom, dad, brothers, sisters or any other loved ones.

_____
_____
List any medications you are taking_____

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

CHIROPRACTIC WORKS
DR. JAMES CASSILLO

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towrds the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which cause alteration of the nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to elimiante a major interference to the expression on the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,_____have read and fully understand the above statements.
(print name)

All questions regarding the doctor's ofjectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

CHANGING THE WORLD ONE SPINE AT A TIME!

Attachment 9-5

Notice of Privacy for: Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Workers Compensation Claim to verify that treatment has been rendered.
- To determine patient 's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign-In logs may be disclosed to verify office visits

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: James W. Cassillo and can be reached at: 516-295-6666 regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient (print) Signature of Patient/Legal Representative Date