MUNROE CHIROPRACTIC

6035 Main Street | Williamsville, NY 14221
P: 716-632-4476 | F: 716-632-4503

Today's date:

HEALTH QUESTIONNAIRE

In order to save time, and better serve you, please complete all questions.

Name: *(First)* ________________ *(M)* ____________ *(Last)* ________________ Date of Birth: ____________

Gender: ____________ Sex at birth: ☐ M ☐ F Preferred Name/Pronoun: ________________

Address: ________________________ City: ________________ State: ______ Zip: ________

Home#: ________________ Cell#: ________________ Preferred #: H C

Primary Care Physician *(Name, Address, and telephone number)*: ________________________________

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Whom may we thank for referring you to our office? ________________________________

Who can we contact in case of an emergency? ________________________ Phone#: ____________

Main Complaint: Why are you here today? Be specific with location: ________________________

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1. When did it start? Date: ____________________
2. How did it start? Explain: ____

Pregnancy/ Birth History

Current weight: ____________ Birth weight: ____________ APGAR Score: ____________

Any pregnancy complications: ____

Any labor complications: ________________________ Did you have a C Section: ____________

Were forceps or vacuum assistance used: ____________ Any Congenital Anomalies: ____________

Milestones and Development

What age did your child start holding their head: ____________

What age did your child start rolling: ____________ What age did your child start crawling: ____________

What age did your child start standing: ____________ What age did your child start walking: ____________

Asymmetries

Does your child favor one side while laying, sitting in a car seat or breast feeding: ____________

Does your child tend to use only one hand to reach or grab for things: ____________

Does your child have any sensitivity to touch: ________________________

How do you feel your child is developing: ________________________

Any other problems you would like the doctor to evaluate:______________________________

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Past History

Any major illnesses:______________________________

Any food allergies:______________________________

Any skin sensitivities:______________________ Any problems with constipation:______________________

Any problems with reflux:______________________ Any feeding/sucking difficulties :______________________

Any major falls:______________________ Does your child take any medications:______________________

Do any diseases run in your family:______________________

Does your child sleep through the night :______________________

Is your child on a regular sleep schedule:______________________

Attention: Payment is to be made at the time of the visit unless prior arrangements have been made with this office. By signing below, you grant consent to any procedures or treatments necessary for treatment of any condition as deemed reasonable by the attending doctor.

Patient or Parent/Guardian Signature: ______________________________ Date:______________________

Office use only:

Acct# ______________ *CA who entered pt in CT:* ______________________ **Doctors initials:**______________________

MUNROE CHIROPRACTIC PATIENT PRIVACY NOTICE

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

Munroe Chiropractic is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from our office. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

MUNROE CHIROPRACTIC MAY USE AND/OR DISCLOSE YOUR PHI FOR THE FOLLOWING REASONS:

- **Treatment**: In order to provide you with the healthcare you require our office will provide your PHI to those health care professionals, whether on our staff or not, directly involved in your care so that they may understand your health condition and needs.
- **Payment:** In order to get paid for services provided to you we will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
- **Health Care Operations:** In order for our office to operate in accordance with applicable law and insurance requirements and in order for the office to continue to provide quality and efficient care, it may be necessary for us to compile, use and/or disclose your PHI.

Munroe Chiropractic may also use and /or disclose your PHI without your specific authorization in the following additional instances:
De-Identified Information Business Associate / Personal Representative Emergency Situations / Public Health Activities Abuse, Neglect or Domestic Violence / Health Oversight Activities Judicial and Administrative Proceedings / Law Enforcement Purposes / Coroner or Medical Examiners / Sign-In Sheet Referral Board / Avert a Threat to Health or Safety / Specialized Government Functions / Workers' Compensation National Security and Intelligence Activities / Military and Veterans Family Member or any other person identified by you
Munroe Chiropractic's additional uses of your information:
New Patient Letter Telephone Messages / Personal Acknowledgement Cards / Appointment Reminder Cards

Uses and/or disclosures, other than those listed above will be made only with your written authorization.

YOUR RIGHTS: You have the right to...

- Revoke any authorization in writing, at any time.
- The right to request restrictions on the use and disclosure of your Protected Health Information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your Protected Health Information
- The right to amend or submit corrections to your protected health information.
- The right to receive and accounting of how and to whom your Protected Health Information has been disclosed.
- The right to receive a printed copy of this notice.
- Complain to Munroe Chiropractic or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated.
- To obtain more information on or have your questions about your rights answered, you may contact Marianne Millidge at 632-4476 or via e-mail at marianne @munroechiropractic.com

MUNROE CHIROPRACTIC'S REQUIREMENTS:

- We are required by Federal Law to maintain the privacy of your PHI and to provide you with this privacy notice.
- We are required by New York State Law to maintain a higher level of confidentiality with respect to certain portions of your medical information than is provided under Federal Law. The particular state statutes are posted in our reception area.
- We are required to abide by the requirements of this privacy notice.
- We reserve the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for all of your PHI that it maintains.
- We will distribute any revised privacy notice to you prior to implementation.
- We will not retaliate against you for filing a complaint.

THIS NOTICE IS IN EFFECT AS OF APRIL 14, 2003.

Munroe Chiropractic, PC
6035 Main Street
Williamsville, NY, 14221
Phone 716-632-4476 Fax 716-632-4503

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language I can understand.

____
Name of Individual

____
Signature of Individual

____
Signature of Legal Representative

____
Relationship
(e.g, Attorney-In-Fact, Guardian, Parent if a minor)

Date signed:________________________

Witness:________________________

MUNROE CHIROPRACTIC, P.C.
6035 Main St. Williamsville, NY 14221
716-632-4476 or 63-CHIRO
(Fax: 716-632-4503)

CONSENT TO TREAT A MINOR CHILD

I hereby authorize Dr. Kenneth Munroe, Dr. Aaron Mierzwa, Dr. Matthew Millanti, Dr. Safeya Muhammad and Dr. Danielle Walsh to administer chiropractic care as deemed necessary.

To my ______________________________ **(indicate relationship of child)**

Name of child: ____

Parent or Guardian: ____

Witnessed by: ____

Date: ____

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