WELCOME

To the place where wellness comes naturally!

Thank you for choosing D.R.E.A.M. Wellness ™. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. (Please Print)

Name _____ Date _____ Birth date ___/____/___ S/S _____-____-_____

Sex: □ Female □ Male
Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone_____ Cell_____ Please circle best way to contact

Email _____ **(only used for announcements and cancellations through this office)**

Are you: □ Married □ Divorced □ Widowed □ Separated □ Single □ Living with significant other

Number Of Children (if any) _____

Spouse, Domestic partner, or Guardian's name _____ Phone # _____

Person to contact in case of emergency _____ Phone # _____

Your employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Who referred you to our office or how did you hear of our office?_____

Have you ever been to a Chiropractor previously? Y N

May we place your name on our "Thank You Board" if you refer someone or in our newsletters? Y N

Please circle reason for visit Wellness Evaluation/Symptoms/Car Accident/Work Injury/Other:_____

Please describe reason for visit (please include when it started, location and description of problem)

_____

_____

_____

Prior Treatments: _____

Does your problem affect any of the following (please circle all that apply):

Bathing	Standing	Lifting	Exercise
Drying Hair	Sitting	Straining	Golf
Cleaning	Reclining	Coughing	Tennis
Sleeping	Walking	Sneezing	Hobbies
Driving	Kneeling	Sleeping	Other:_____

List all medications currently taking _____

List all supplements/vitamins currently taking _____

(Women) Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Do you smoke? Y N How much per day? _____

How much alcohol do you consume weekly? _____

Do you have any additional medical records you would like us to review? Y N

Do you exercise? Type:_____ How Long?_____

Health History *(please circle those that apply)*

Hepatitis, Allergies, Osteoporosis, Alcoholism, Hernia, Dizziness, Tinnitus, Fainting, Infertility, Eye Problems, Vision Problems, Insomnia, Circulatory Disorder, Cold Hands, Cold Feet, Depression/Anxiety, Aids/HIV, Drug Dependency, Stroke, Herniated Disc, Thyroid Problems, Fractures, Bleeding Disorders, Diabetes, High Cholesterol, Eating Disorders, Tumors, Growths, Urinary Problems, Migraines, Headaches, Liver problems, Prostate Problems, Constipation, Diarrhea, Arthritis, Asthma, Epilepsy, Seizures, Neurological disorder, Emphysema, Kidney Problems, Cancer, Heart Disease, Miscarriages, Prosthesis, Psychiatric care, other: _____

_____

_____

_____

_____

_____

On a scale of 1 – 10, rate the importance for you to achieve the following:
1 = not important 10 = necessary

Get fit	1	2	3	4	5	6	7	8	9	10
Eat better	1	2	3	4	5	6	7	8	9	10
Reduce stress	1	2	3	4	5	6	7	8	9	10
Stop smoking	1	2	3	4	5	6	7	8	9	10
Reduce pain	1	2	3	4	5	6	7	8	9	10
Increase my mobility	1	2	3	4	5	6	7	8	9	10
Improve my posture	1	2	3	4	5	6	7	8	9	10
Improve my sleep	1	2	3	4	5	6	7	8	9	10
Learn about wellness	1	2	3	4	5	6	7	8	9	10
Learn about wellness products that are right for me	1	2	3	4	5	6	7	8	9	10
Other _____	1	2	3	4	5	6	7	8	9	10

Which of the above would you say is the most important goal for you to achieve and why? _____

_____

Would you like us to send a report to you primary medical doctor or any other doctor? (if yes, please fill out)

Doctor's Name:_____ Specialty:_____

Address and Phone Number:_____

Doctor's Name:_____ Specialty:_____

Address and Phone Number:_____

Would you like us to verify your insurance? If yes, please complete the following info:

Whose insurance is this? _____ Relationship to insured _____

Insured's SS# ___/___/____ Insured's DOB ____/____/____ Insured's Employer _____

Insurance Company: _____

Insurance ID#:_____ Group #:_____

Do you have any questions or comments? _____

We look forward to helping you D.R.E.A.M. Wellness

Authorization: I certify that I have read and answered accurately all of the above questions. I authorize Dr. Glassman to release any information to a third party payer and/or health care provider regarding my care. I authorize and request my insurance company to pay Dr. Glassman directly. I am aware that Dr. Glassman is an out of network provider and I am aware that I may be financially responsible for services that are not covered by my insurance company, including deductibles, and or co-pays.

X: _____ Date:_____

D·R·E·A·M wellness

38 Great Neck Road
Great Neck, N.Y. 11021
(516) 829-8099 (o)
(516) 829-8578 (f)
www.dreamwellness.com

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 Worker's Compensation Claim to verify that Chiropractic services have 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 *Adam Glassman, D.C.*, and can be reached at *516 829-8099* 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 read and reviewed this notice with full understanding.

_____
Patient Name (Print)

_____ _____
Signature of Patient/Legal Representative Date

D·R·E·A·M wellness

Dr. Adam Glassman, D.C. C.A.C.C.P.
24A Great Neck Road
Great Neck, N.Y. 11021
(516) 829-8099 (o)
(516) 829-8578 (f)
www.dreamwellness.com

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE TREATMENT

Patient Signature / Date_____ Doctor's Signature:_____

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Signature of Parent/Representativen for Patient: _____