

Welcome To

Blue Star Chiropractic

DR. EVE CAPKANIS AMHERST, MA

Today's Date _____

Personal Data

Name _____ Age _____ Date of Birth _____

Home Phone (____) _____ Email address _____

Home Address _____ City _____ State _____ Zip _____

Marital Status S M D W L/W Name of Spouse _____

Parents' names (if you are under 18) _____

Occupation _____ Employer _____

Business Address _____ City _____ State _____ Zip _____

Business Phone (____) _____ SS# _____

Whom may we thank for referring you to Blue Star Chiropractic? _____

Reason For Seeking Chiropractic Care

What concerns do you feel Blue Star Chiropractic can address for you? _____

Is this concern affecting any of the activities below? (Please circle)

Work: Yes No Recreation/play: Yes No Sleep: Yes No

Social Life: Yes No Walking: Yes No Sitting: Yes No

Exercise: Yes No Eating: Yes No Love life: Yes No

Other Data

Have you ever received Chiropractic care? Y N With Whom? _____

Date of last visit: _____ Why did you stop care? _____

Do you have a family medical doctor? Y N Who? _____

Do you consult him/her regularly? Y N If so, why? _____

Date of last medical consultation and result: _____

Health, Wellness and Chiropractic Care

Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be **PHYSICAL, CHEMICAL, or EMOTIONAL** in nature. Understanding the **PHYSICAL, CHEMICAL, or EMOTIONAL** stresses that have acted upon your spine and nerve system assists us in serving you. Please answer the following questions as accurately and completely as possible.

History of Physical Stresses (Birth to Present)

Birth Stress

Research indicates that the birth process can cause trauma to a baby's spine and nerve system. Please indicate to the best of your recollection how you were birthed:

Was your birth: (check all that apply)

drug induced	C section	breech	natural	forceps
prolonged	cord around neck	at home	in hospital	suction

General Physical Trauma

Most trauma occurs in the early years (between birth and age 18-21). It is during those years that your spine and nerve system is growing and most impressionable. The information below will help us to see the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (check all that apply and give dates)

automobile (even as a passenger) motorcycle bicycle sports other _____

If yes, please explain how and when: _____

Have you ever injured your spine (neck, head, back, hips)? yes no

If yes, please explain how and when: _____

Have you ever broken any bones or sprained any part of your body? yes no

If yes, please explain how and when: _____

Have you ever been hospitalized? yes no

If yes, please explain how and when: _____

History of Chemical Stresses

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed in the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Have you been vaccinated?	yes	no		
Do you or have you ever taken?	prescription drugs	over the counter drugs	recreational drugs	
Have you been exposed to?	chemicals	fumes	dust	smoke
Do you consume?	alcohol	coffee/caffeine	tobacco	

List Current Medications: _____

Any Medications Previously taken for more than 6 months? _____

History of Emotional Stresses

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below. (Please circle)

Childhood trauma	Yes	No	Loss of loved one	Yes	No	Relationships	Yes	No	Family	Yes	No
Work or School	Yes	No	Divorce/separation	Yes	No	Financial	Yes	No	Abuse	Yes	No
Lifestyle change	Yes	No	Parents' divorce	Yes	No	Illness	Yes	No	Other	Yes	No

Quality of Life

How do you grade your physical health?	Good	Fair	Poor
How do you grade your emotional/mental health?	Good	Fair	Poor
How do you rate your overall "quality of life"?	Good	Fair	Poor

Please check the choice that most clearly describes your current goals for Health and Well-being

(Check all that apply):

I am only concerned with my immediate problem.

I am only concerned with my immediate problem and preventing its return.

I want optimum health and well-being on every level that is available to me.

Financial Information

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

Please indicate your method of payment: cash check credit card

Signature _____ Today's Date _____

Signature of Parent (for minor) _____

***Thank you for choosing Blue Star Chiropractic.
We are looking forward to helping you develop a healthier spine and
nerve system.***

Privacy Notice Acknowledgement

WE AT BLUE STAR CHIROPRACTIC ARE VERY CONCERNED WITH PROTECTING YOUR PRIVACY, ESPECIALLY IN MATTERS THAT CONCERN YOUR PERSONAL HEALTH INFORMATION. IN ACCORDANCE WITH THE *HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)*, WE ARE REQUIRED TO SUPPLY YOU WITH A COPY OF OUR PRIVACY POLICIES AND PROCEDURES. WE ENCOURAGE YOU TO READ THIS DOCUMENT CAREFULLY, FOR IT OUTLINES THE USE AND LIMITATIONS OF THE DISCLOSURE OF YOUR HEALTH INFORMATION AND YOUR RIGHTS AS A PRACTICE MEMBER/PATIENT. IF YOU EVER HAVE ANY QUESTIONS OR CONCERNS REGARDING THE USE OR DISSEMINATION OF YOUR PERSONAL HEALTH INFORMATION, WE WOULD BE HAPPY TO ADDRESS THEM.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF BLUE STAR CHIROPRACTIC'S *NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION*.

PATIENT NAME PRINTED

DATE

PATIENT SIGNATURE

CC REPRESENTATIVE

PERSONAL REPRESENTATIVE PRINTED

PERSONAL REPRESENTATIVE SIGNATURE

CC REPRESENTATIVE

Description of personal representative's authority to act for the patient/practice member (i.e. relationship).

BLUE STAR CHIROPRACTIC
DR. EVE CAPKANIS
441 WEST ST., AMHERST, MA 01002
413-537-2251

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for care, it is essential for both to be working together towards 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 adjustments of the spine.

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

Vertebral Subluxation A misalignment of one or more of the 24 vertebra in the spine column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in the lessening of the body's innate ability to express its maximum health 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 service of a health care provider that 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 eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

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

Signature _____ Date _____

