



Gregory J. Gorman, D.C.

Evolutionary Chiropractic

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Comprehensive Health Profile

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____

State: _____ ZIP: _____ Home Phone: _____ Cell: _____

e-mail: _____ Date of Birth: _____ Sex: M F

Marital Status: S M D W Occupation: _____

How did you discover my office and the professional services I provide?

Please complete this general health history and wellness survey. It will provide Dr. Gorman with information to better understand your history and long term needs, as well as any wellness or health related quality of life issues you may now be experiencing.

Part I: Your Health Concern and how it affects your life.

1. Do you have a current health/life situation or concern that caused you to seek my help? If so, please describe.

2. When did this issue begin? _____

3. Have you done anything about this situation? Yes No

4. What was done? _____

5. Did it seem to work? Yes No

6. Did the treatment change your condition? Yes No

7. Please describe how your condition or situation is affecting your life.

0 - Does not affect me at all

1 - It slightly affects me

2 - It moderately affects me

3 - It dramatically affects me

Work 0 1 2 3

Social Life 0 1 2 3

Exercise 0 1 2 3

Recreation 0 1 2 3

Walking 0 1 2 3

Eating 0 1 2 3

Sleep 0 1 2 3

Sitting 0 1 2 3

Love Life 0 1 2 3

8. Do any family members have the same or a similar condition? Yes No

9. Is there any a time of day where this condition is better or worse?

10. Why do you think this is happening to you?

11. Do you think this is the sole cause? Yes No

12. What else might be contributing to the issue? _____

13. How would your life be different if this condition/symptom/concern were to go away?

14. What are you doing differently in response to this condition/symptom/concern?

15. Which best describes your current feeling about yourself and your situation.

Choose one.

- a. I feel helpless, like little or nothing works.
- b. This is terrible. I am scared and hope you can fix it for me.
- c. I feel stuck and can't help myself right now.
- d. I deserve more than this and hope you can assist me in healing.
- e. other _____

16. What is your goal in seeking my professional services?

Part II: Health/Trauma/Medical/Chiropractic History

1. Have you ever injured your spine (neck, head, back, hips)? Yes No

- a. Date of most significant injury_____
- b. What happened?_____
- c. Date of most recent injury_____
- d. What happened?_____

2. Please list any medications you are currently taking and the reason they were prescribed.

3. Please list any supplements, herbs and/or homeopathic remedies you are currently taking?

4. Have you had spinal x-rays, CT scans or MRI imaging of the spine, head neck, back or hips? Yes No If yes:

- a. When?_____
- b. What were you told about the findings?_____
- c. Where are they now?_____

5. Have you had any surgeries? Yes No If yes, please explain:_____

6. Have you broken any bones or significantly sprained any part of your body?

Yes No If yes, please explain:_____

7. Have you consulted a physician or any other health care provider in the past three months? Yes No If Yes, please explain:_____

8. Have you had your spine professionally manipulated or adjusted? Yes No If Yes:

a. By whom and when? _____

b. Why did you go? _____

c. Are you still going? Yes No
If Yes, date of last treatment? _____

d. What did he or she do for you? _____

e. Were you pleased? Yes No

9. Have you experienced any of the following types of health care or healing modalities?

Massage/Bodywork	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteopathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physiotherapy/Occupational Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Homeopathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ayurvedic Medicine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Acupuncture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nutritional Counseling/Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Yoga	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pilates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____		

10. Do you currently exercise? Yes No If yes, please describe the activity and the frequency _____

11. Please describe any unusual stresses you may be experiencing in your life.

12. Please grade the following stresses in order of increasing intensity.

- 0 - No awareness of stress 1 - Slightly stressful
2 - Moderately stressful 3 - Extremely stressful

a. Overall Physical Stress: 0 1 2 3

includes falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse.

b. Overall Mental/Emotional Stress: 0 1 2 3

includes loss of loved ones, rapid change in life situation, mental, emotional and/or sexual abuse, legal concerns, financial concerns, move of home/school separation/divorce, relationship stress, chronic illness.

c. Overall Chemical Stress: 0 1 2 3

includes drugs, smoke, fumes, food additives, etc.

d. Have you had a work related accident?

Yes No If Yes, please describe

e. Have you had a motor vehicle accident?

Yes No If Yes, please describe

Part III: Your specifics needs and goals for help in this office.

1. How do you hope to benefit from care in this office? Please rate on the following scale:

1. Very important 3. Not so important
2. Important 4. Does not apply

- a. Improvement of my physical symptoms. 1 2 3 4
b. Improvement of my emotional/mental symptoms. 1 2 3 4
c. Improvement of my ability to respond to stress. 1 2 3 4
d. Improvement in enjoyment of life and the ability to make constructive choices. 1 2 3 4
e. Overall improved quality of life. 1 2 3 4

2. For a slightly longer term goal, how do you hope to benefit from care in this office?

- a. Improvement of my physical symptoms. 1 2 3 4
b. Improvement of my emotional/mental symptoms. 1 2 3 4
c. Improvement of my ability to respond to stress. 1 2 3 4

- d. Improvement in enjoyment of life and the ability to make constructive choices. 1 2 3 4
- e. Overall improved quality of life. 1 2 3 4

3. Is there some aspect of your life that you feel is working? That brings you joy, pleases you or helps you to feel better about yourself? _____

4. Are there any aspects of your life you feel will impair your ability to be well and healthy? _____

5. What aspects of your life will enhance your ability to heal and be well?

Thank you for choosing my office! I am excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.

Gregory J. Gorman, D.C.

Health Privacy Policy

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient Gregory J. Gorman, D.C., we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services.)

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine.

Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters.

If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us.

We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Gregory J. Gorman

If you would like further information about our privacy policies and practices please contact: Dr. Gorman

This notice is effective as of April 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please)

Signature

Date

If you are a minor, or if you are being represented by another party

Printed Name of Guardian

Signature