

North Shore Health Solutions Ltd.

Patient Application Form

WELCOME TO OUR OFFICE. We specialize in assisting people to achieve their highest level of health through our unique and advanced protocols.

You must fill out the following information as thoroughly as possible so we can let you know if we accept your case.

I agree to the above terms, and understand that should I NOT have the paperwork completed I may NOT be seen. I also agree and understand that should I receive a consultation on my case as outlined in this paperwork, that Dr. Martin is assessing my case on the basis of her chiropractic license. I agree and understand that it is my responsibility to seek appropriate medical care in such cases.

Signature _____

Today's Date ____/____/____

**PLEASE BRING THIS PAPERWORK TO THE OFFICE TO YOUR SCHEDULED APPOINTMENT or
FAX/SCAN/RETURN PRIOR TO YOUR CONSULTATION.**

**BE SURE TO SEND ALL CURRENT (NO MORE THAN 3 MONTHS OLD) BLOOD WORK AT LEAST 3
DAYS PRIOR TO YOUR APPOINTMENT.**

You may also have it faxed to our office ahead of time from your Doctor's Office.

North Shore Health Solutions Ltd. 1446 Techny Road, Northbrook, IL 60062

Office 847.715.9060 Fax 847.715.9460

General Information

Name: _____ Gender: **M** **F**

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Birth Date: ____/____/____ Age: _____ Marital Status: _____

Height: _____ Weight: _____ lbs Weight gain / loss in past 18 months: _____

of Children: _____ Ages: _____ Occupation: _____

Employer Name: _____

How were you referred to this office? _____

A \$25.00 charge will be added to any card on file for failing to cancel/reschedule an appointment with AT LEAST a 24 hour notice. Also, due to office policy and health regulations, all supplement sales are final and cannot be returned

Purpose of this Visit

Reason for this visit – Main Complaint: _____

When did this condition begin? ____/____/____ Did it begin: Gradual Sudden Progressive over time

Is there anything which has relieved your symptoms? **Yes** **No** Describe: _____

Is this condition getting worse? **Yes** **No** Explain: _____

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine Explain: _____

Have you experienced this condition before? **Yes** **No** If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Reason for this visit – Second Complaint: _____

When did this condition begin? ____/____/____ Did it begin: Gradual Sudden Progressive over time

Is there anything which has relieved your symptoms? **Yes** **No** Describe: _____

Is this condition getting worse? **Yes** **No** Explain: _____

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine Explain: _____

Have you experienced this condition before? **Yes** **No** If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

Experience with Doctors

Have you seen a Medical Doctor for this condition? **Yes No** Who? _____ When? _____

Type of Specialty: _____

How did you respond / What was recommended? _____

Did your previous doctors take X-Rays, MRI, or CT scan? **Yes No** Did you receive other diagnostic tests? **Yes No**

Type and results: _____ **Please BRING a copy of the results**

Have you received any Blood Analysis/Blood testing within the past 18 months? **Yes No** **Please BRING a copy of the results.**

Have you seen a chiropractor before? **Yes No** Who? _____ When? _____

Reason for visits: _____ How did you respond? _____

Family Health History

List any health history issues in your family: _____

Family history of: **Arthritis, Rheumatoid Arthritis, Juvenile RA, Lupus, Diabetes I or II, Hashimotos Ds, Sarcodosis, Psoriasis, Celiac Ds, Gout, Cancer, Heart Disease** Who, and who had what? _____

Are your parents still living, healthy, and if not healthy, please explain details with their ages:

Please give me any other detail possible on family history:

Personal Health History: Blood Born Disease - HIV, AIDS, Bleeding Disorder, Herpes, STD/STI, Gout, Hep A, B, C

When were you diagnosed and by whom? _____

Personal Health

BRAIN AND CERVICAL:

Do you currently experience: (Please write 'past' if you did experience this but are not currently)

- | | | |
|--|--|--|
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Attention deficit / Focus issues | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Memory Loss / Forgetfulness | <input type="checkbox"/> Early Dementia Issues | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Depression / Sadness | <input type="checkbox"/> Difficult / Dislike social situations | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Emotional Swings | <input type="checkbox"/> Anxious / Panic Attacks | <input type="checkbox"/> Coldness in hands |
| <input type="checkbox"/> Anger / Frustration | <input type="checkbox"/> Phobias / Addictions | <input type="checkbox"/> Thyroid Conditions |
| <input type="checkbox"/> Unclear Thinking | <input type="checkbox"/> Neck Pain, soreness, achy | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Mixing up data | <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Difficult speech / Can't find words | <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Recurrent colds/flu |
| <input type="checkbox"/> Procrastination / Disorganized | <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Low energy/fatigue |
| <input type="checkbox"/> OCD or early OCD symptoms | <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> TMJ/Pain/Clicking |

HEART / LUNGS / DIGESTIVE

Do you currently experience: (Please write 'past' if you did experience this but are not currently)

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Asthma / Wheezing | <input type="checkbox"/> Heart Murmurs |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> ANY history of Auto-Immune Ds |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Fatigue between meals | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis |
| <input type="checkbox"/> Mid / Upper Back Pain | <input type="checkbox"/> Reflux / Ulcers | <input type="checkbox"/> Hypoglycemic Symptoms |
| <input type="checkbox"/> Pain into your ribs/chest | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Tired/Irritable after eating or when you haven't eaten for a while |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Diabetes / Insulin resistance | |

STRUCTURE:

Do you currently experience: (please write 'past' if you did experience this but are not currently)

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Coldness in your legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping (Females) |
| <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Sexual dysfunction | |

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose:

Please list all past surgeries:

Please list all previous accidents and falls:

How supportive is your Spouse/Family/Significant other to you seeking care? (be specific)

Are you willing to make dietary changes and possibly take supplements necessary for your recovery? **Yes** **No**

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, ect.) Give 3 examples.

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

What do you desire most to get from working with us?

Please list anything else we should know that would help us assess your case:

I attest to all of the above pages being true and complete to the best of my ability. I understand that chiropractic care with any/all of the doctors North Shore Health Solutions Ltd, Dr. Martin may or may not be appropriate for my case and that completion of this paperwork does not mean I have been accepted for care.

Signature: _____ Date: _____

Metabolic Assessment Form™

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI (Cont.)

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII (Males Only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII (Males Only)

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX (Menstruating Females Only)

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX (Menopausal Females Only)

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental foggiess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

List the three worst foods you eat during the average week: _____

List the three healthiest foods you eat during the average week: _____

PART IV

Please list any medications you currently take and for what conditions: _____

Please list any natural supplements you currently take and for what conditions: _____

NEUROLOGICAL ASSESSMENT FORM

Patient Name _____

Date _____

- | | Right | Left |
|--|-------|------|
| 1. Are you left or right handed? _____ | | |
| 2. Have you had a head injury? _____ | YES | |
| 3. Have you noticed your ability to concentrate is getting worse? _____ | YES | NO |
| 4. Does driving cause you <i>fatigue, headaches, or any other symptoms</i> ? <u>←(circle)</u> _____ | YES | NO |
| 5. Does working on a computer cause you fatigue, headaches, or other symptoms? _____ | YES | NO |
| 6. Have you lost your interest in hobbies and functions that you used to enjoy? _____ | YES | NO |
| 7. Do you have any changes in smell or smell foul things that are not present? _____ | YES | NO |
| 8. Do you have difficulty with taste or taste things differently than what you are eating? _____ | YES | NO |
| 9. Do you have difficulty with short-term memory? _____ | YES | NO |
| 10. Have you been told or noticed any memory loss of past events? _____ | YES | NO |
| 11. Do you experience Déjà vu? _____ | YES | NO |
| 12. Do you ever experience flashes of light in your visual field? _____ | YES | NO |
| 13. Do you get lost often or have a hard time with directions? _____ | YES | NO |
| 14. Do you currently experience or have a past history of vertigo or balance disorders? _____ | YES | NO |
| 15. Noticed clumsiness in hand coordination? Which Hand? <u>Right / Left ← (circle)</u> _____ | YES | NO |
| 16. Do you find that your balance is getting worse? _____ | YES | NO |
| 17. Do you have any <i>tightness, weakness, or instability</i> in your <i>back or neck</i> ? <u>← (circle)</u> _____ | YES | NO |
| 18. Do you ever have slurred speech? _____ | YES | NO |
| 19. Do you have difficulty with math problems, or remembering numbers? _____ | YES | NO |
| 20. Do you find yourself searching for words frequently when you speak? _____ | YES | NO |
| 21. Do you get motion sickness easily (car sick or sea sick)? _____ | YES | NO |
| 22. Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? _____ | YES | NO |
| 23. Do you have difficulty distinguishing right and left? _____ | YES | NO |
| 24. Do you get motion sickness easily (car sick or sea sick)? _____ | YES | NO |
| 25. Do you have any difficulty with falling asleep or staying asleep? _____ | YES | NO |
| 26. Noticed uneven sweating or temperature on one side of your body? _____ | YES | NO |
| 27. Do quick flashes of light on TV or loud noises bother you? _____ | YES | NO |
| 28. Do you get motion sickness easily (car sick or sea sick)? _____ | YES | NO |
| 29. Do you experience <i>blurriness in your vision</i> or <i>double vision</i> ? <u>← (circle)</u> _____ | YES | NO |
| 30. Do you have a hard time swallowing? _____ | YES | NO |
| 31. Do you gag easily? _____ | YES | NO |
| 32. Do you experience nausea? _____ | YES | NO |
| 33. Do you ever experience dry eyes or mouth? <u>←(circle)</u> _____ | YES | NO |
| 34. Do you ever experience increase <i>tearing or salivation</i> ? <u>←(circle)</u> _____ | YES | NO |
| 35. Noticed any drooping of your <i>eyelids</i> or <i>facial muscles</i> ? <u>←(circle)</u> _____ | YES | NO |
| 36. Has your handwriting changed in recent years? _____ | YES | NO |
| 37. Do you ever have fluttering of the eye or noticed you are blinking frequently? _____ | YES | NO |
| 38. Do you ever have any <i>numbness or tingling</i> in your <i>hands, legs, or face</i> ? <u>← (circle)</u> _____ | YES | NO |
| 39. Do you have difficulties walking down stairs? _____ | YES | NO |
| 40. Do you have any ringing or pressure in the ears? _____ | YES | NO |
| 41. Do you ever notice increased heart rate (tachycardia) or pulse during the day? _____ | YES | NO |
| 42. Do you have any <i>tightness, or feelings of weakness</i> in your <i>hands or legs</i> ? <u>← (circle)</u> _____ | YES | NO |

Patient Signature _____

Date _____

Patient's Statement of Privacy Rights

As a patient of North Shore Health Solutions, you have a right to privacy to your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPPA). HIPPA was enacted to give you, the patient of a health care provider and covered under health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect as the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPPA the charge is not to exceed \$20.00 handling charge for processing the request for copies and a .75 cents per page for the first 25 pages, .50 cents per pages 26-50 and .25 cents per page for all pages in excess of 50.
4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request.)
5. While the doctor has the right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he/she shall supply you with written notification of such disagreement.
6. The doctor has the right to rebuttal to the patient's disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.
7. You have a right to specify how access to your health information is restricted and from whom.
8. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
9. All covered entities under HIPPA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by HIPPA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of the "chain of trust" under applicable Business Associate Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
10. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization.
11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
12. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPPA in establishing that standard.
13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPPA.
14. You have the right to contact the Department of Health and Human Services, Office of Civil Rights, which administers HIPPA, with questions or to file a complaint at, Toll Free: 1-877-696-6775 or E-mail: www.hhs.gov/ocr

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

Patient Signature: _____

Date: ____/____/____

North Shore Health Solutions Informed Consent

Date: _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as a backup for the Doctors of Chiropractic named below, including those working at the clinic or office listed below.

The nature of chiropractic treatments: The doctor will use her hands or mechanical device in order to move your joints. You may feel a "click" or "pop", such as the nose when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as cold packs, mechanical traction, manual traction, or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fracture of a bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to the intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. The probability that delay of treatment will complicate the condition and make future rehabilitation more difficult is very high.

I understand and am informed as to the nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the below Doctor of Chiropractic and or his/her associates and assistants, and do not expect the Doctor to be able to anticipate and explain all the risks and complications, and wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts then known, is in my best interests.

North Shore Health Solutions, Ltd.

Dr. Kim Martin DC FASA

I have read, or have had read to me, the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Patient Name Printed: _____

Patient Signature: _____