Patient and Family History

Patient Name: _____ **Birthdate:** _____ **SEX: M / F**

Address: _____ **City:** _____ **State:** _____ **Zip code:** _____

Email: _____ **Phone (____)** _____

Insurance Name: _____ **Subscriber ID#:**_____

Spouse Name: _____ **Employer:** _____

Smoking Status: _____ **Race:** _____ **Ethnicity:** _____

How did you hear about our office? _____

What is your main complaint? _____

Have you ever experienced this pain before? _____ **If so, when did it begin?** _____

Have you ever seen anyone for this complaint in the past? _____

What makes your complaint feel better (*ice, stretch*)? _____ **What makes it worse?** _____

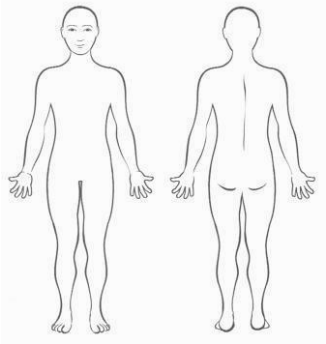
What is the *severity* of your complaint? Please mark it on the scale below.

No pain	Slight Pain	Some Pain			Affects Some Work		Affects All Work		Bedridden
1	2	3	4	5	6	7	8	9	10

What is the percentage of time that you experience your main complaint?

10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

On the diagram below, please mark where you are experiencing your complaint:



Personal History
Please Circle all that Apply:

Stroke	High cholesterol
Heart Disease	Genetic disorder
Cancer	Bleeding disorder
High Blood Pressure	Irregular Menstrual Cycle
Fatigue	Frequent Urination
Kidney stones	Headaches
Loss of consciousness	Arthritis

Have you ever been hospitalized or had surgeries? _____

Have you ever had any broken bones? _____

Have you ever been in an auto accident? _____

What medications and/or supplements do you take? _____ _____ ___

Do you have any serious medical problems not listed above? _____

Family History: ☐ **Cancer** ☐ **Diabetes** ☐ **High Blood Pressure** ☐ **Heart Problems/Stroke** ☐ **Rheumatoid Arthritis**

Are you pregnant? _____ **Have you seen a Chiropractor before? If so, when?** _____

Do you want a TEXT MESSAGE or EMAIL APPOINTMENT REMINDER sent to you? ☐ **TEXT** ☐ **EMAIL** ☐ **NONE**

SEE NEXT PAGE _ PAGE 1 OF 2

DOCTOR USE ONLY: BP: _____/_____ **Height:** _____ **Weight:** _____

Doctor Signature: _____

INITIAL ALL HIPAA REGULATIONS:

In this document "I" and "my" refer to the patient, and "Chiropractor" refers to Point Loma Chiropractic.

_____ I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

_____I understand that I have the right to request a restriction to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. If Chiropractor agrees to restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent in writing at any time, except to the extent that Chiropractor has taken action to this consent. My "protected health information" means health information, including my demographic information collected from me by my physician, another health care provider or a health plan my employer or clearinghouse may obtain. This protected health information relates to my past, present or future physical or mental health condition and identifies me or there is a reasonable basis to believe the information may identify me.

_____I would like my medical/ personal information to be able to be shared with _____. If I choose to change my preference, I will notify Point Loma Chiropractic in writing.

_____I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information.

INFORMED CONSENT

_____Chiropractic care contributes to your overall wellbeing. The risk of injury or complications from treatment is substantially lower than that associated with many medical or other treatment, medications and procedures given for the same symptoms. Also, as your body begins to be restored to normal health, there may be some periods of time where you may feel the same symptoms that were previously gone. Understand that this is normal and indicates healing.

In accordance with CA Law this notice is to inform you as a patient of the material risks of undergoing Chiropractic care. This means that there are known inherent risks from a particular treatment. Since the literature is vague and sometimes biased and it is not absolutely known that there are any material risks from chiropractic care. This painless, logical and effective approach to healthcare has been serving people every day for over 100 years. It is licensed in every state and in most countries.

Chiropractic has the lowest incidence of any reported side effects than any other healthcare profession. Evidenced by our extremely low malpractice rates, the procedures that will be performed in the course of your care will consist of gentle chiropractic manual adjustments, and light force instrument posture balancing. You may receive cold laser therapy, flexion distraction for low back and disc pain and Active Release Technique "ART", Graston, Electrical Stimulation, Therapeutic Ultrasound or Taping.

In the history of Chiropractic there has been an extremely rare rate of occurrence for muscle spasms, tightness, rib fracture and disc injuries. Also, there have been medical reports of a possible connection to stroke although unconfirmed in the literature. There is virtually zero risk of this happening from chiropractic treatment. The largest study was done in 2001 by the Canadian Medical Association Journal that there is a 1 in 5.85 million risk that cervical manipulation performed by either an MD, PT or DC would be followed by a stroke. The author, David Cassidy, a professor of epidemiology at the Univ of Toronto said patients had already damaged the artery before seeing help from either a medical doctor or chiropractor than the stroke occurred after the visit.

You may experience some mild symptoms during the healing phase of your care. Please understand that these mild symptoms are normal and indicate healing as your health returns to its optimal state. Finally there are risks of not getting prescribed chiropractic care. These were one of the four components of risks from the Association of Chiropractic Colleges guidelines on informed consent from 2008. They include disc degeneration, loss of mobility, loss of tone and decreased quality of life. I acknowledge that I have discussed or have had the opportunity to discuss all possible risks and treatment with my chiropractor. My Chiropractor has explained these risks to me verbally and in the contents of this form. My signature applies to any and all future treatments in this office.

_____Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____I am aware that there may be videotaping done to help analyze or diagnosis my condition. I consent to the videotaping and realized that the information will not be shared with anyone else unless I have specified so.

_____I am aware that my insurance <u>may not</u> cover all services performed in this office therefore there would be an extra charge of *$15 per visit* for any non-covered services such as ART, Graston, Kinesio-taping, Rapid Release, Cold Laser, etc.

_____This acknowledges Ian Ahearn D.C., Matthew Sanicki D.C., Chris Coulsby, D.C., Carolena Jones and/or those associated with Point Loma Chiropractic are hereby authorized and directed by me to treat my present problem or illness to the best of their ability. In most cases there is a gradual, satisfactory response. Occasionally the results are less than expected. In such cases where the patient is not responding to treatment he/she may be referred to the most appropriate doctor or clinic.

(Standard text messaging rates may apply)

Do you want a <u>TEXT MESSAGE</u> or <u>EMAIL APPOINTMENT REMINDER</u> sent to you? ☐ TEXT ☐EMAIL

Patient Sign: _____ Date: _____

DR. Sign: _____