



CONFIDENTIAL HEALTH INFORMATION

Oak Point Chiropractic
3800 Watt Avenue Suite 120
Sacramento, CA 95821
TEL: (916) 484-0321
FAX: (916) 481-6830
www.oakpointchiropractic.com

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

Whom may we thank for referring you?

☐ No ☐ Yes

When?

If so, whom?

Age

Gender

☐ Male ☐ Female

Race

☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other ☐ White
☐ Decline to answer

Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

☐ Never A Smoker ☐ Former Smoker
☐ Current Every Day Smoker ☐ Current Some Day Smoker
☐ Heavy Smoker ☐ Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status ☐ Married

☐ Single ☐ Divorced

City

State/Province

ZIP/Postal Code

☐ Widowed ☐ Separated

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

☐ Yes ☐ No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

☐ Home Phone ☐ Cell Phone
☐ Work Phone ☐ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

☐ Self ☐ Spouse ☐ Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

PAGE
1/4

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Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

☐ An accident or injury
☐ Work ☐ Auto ☐ Other _____

☐ A worsening long-term problem
☐ An interest in: ☐ Wellness ☐ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication ☐ Acupuncture
☐ Over-the-counter drugs ☐ Chiropractic
☐ Homeopathic remedies ☐ Massage
☐ Physical therapy ☐ Ice
☐ Surgery ☐ Heat
☐ Other _____

Secondary Complaint

The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

☐ An accident or injury
☐ Work ☐ Auto ☐ Other _____

☐ A worsening long-term problem
☐ An interest in: ☐ Wellness ☐ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication ☐ Acupuncture
☐ Over-the-counter drugs ☐ Chiropractic
☐ Homeopathic remedies ☐ Massage
☐ Physical therapy ☐ Ice
☐ Surgery ☐ Heat
☐ Other _____

Additional Complaint

The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

☐ An accident or injury
☐ Work ☐ Auto ☐ Other _____

☐ A worsening long-term problem
☐ An interest in: ☐ Wellness ☐ Other _____

Onset (When did you first notice your current symptoms?) _____

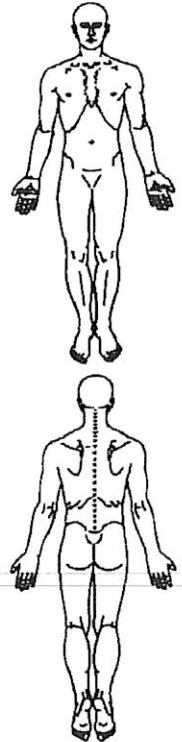
Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication ☐ Acupuncture
☐ Over-the-counter drugs ☐ Chiropractic
☐ Homeopathic remedies ☐ Massage
☐ Physical therapy ☐ Ice
☐ Surgery ☐ Heat
☐ Other _____

Location

(Where does it hurt?)
Circle the area(s) on the illustration.

"O" for current condition
"X" for conditions experienced in the past



1. What else should Oak Point Chiropractic know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Osteoporosis	<input type="radio"/> Arthritis	<input type="radio"/> Scoliosis	<input type="radio"/> Neck pain	<input type="radio"/> Back problems	<input type="radio"/> Hip disorders	Initials _____
<input type="radio"/> Knee injuries	<input type="radio"/> Foot/ankle pain	<input type="radio"/> Shoulder problems	<input type="radio"/> Elbow/wrist pain	<input type="radio"/> TMJ issues	<input type="radio"/> Poor posture	

b. Neurological

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Anxiety	<input type="radio"/> Depression	<input type="radio"/> Headache	<input type="radio"/> Dizziness	<input type="radio"/> Pins and needles	<input type="radio"/> Numbness	Initials _____

c. Cardiovascular

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> High blood pressure	<input type="radio"/> Low blood pressure	<input type="radio"/> High cholesterol	<input type="radio"/> Poor circulation	<input type="radio"/> Angina	<input type="radio"/> Excessive bruising	Initials _____

d. Respiratory

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Asthma	<input type="radio"/> Apnea	<input type="radio"/> Emphysema	<input type="radio"/> Hay fever	<input type="radio"/> Shortness of breath	<input type="radio"/> Pneumonia	Initials _____

e. Digestive

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Anorexia/bulimia	<input type="radio"/> Ulcer	<input type="radio"/> Food sensitivities	<input type="radio"/> Heartburn	<input type="radio"/> Constipation	<input type="radio"/> Diarrhea	Initials _____

f. Sensory

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Blurred vision	<input type="radio"/> Ringing in ears	<input type="radio"/> Hearing loss	<input type="radio"/> Chronic ear infection	<input type="radio"/> Loss of smell	<input type="radio"/> Loss of taste	Initials _____

g. Skin

Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>
<input type="radio"/> Skin cancer	<input type="radio"/> Psoriasis	<input type="radio"/> Eczema	<input type="radio"/> Acne	<input type="radio"/> Hair loss	<input type="radio"/> Rash	Initials _____

Patient name _____

Patient Number
(office use only) _____

Doctor's Initials _____

Oak Point Chiropractic

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name

Patient Number
(office use only)

13. What is the major stressor in your life? _____ 14. How much sleep do you average per night? _____ Hours

15. What is the type and approximate age of your mattress and pillow? _____ 16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Consultation Notes

Doctor's Initials

Oak Point Chiropractic

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

PAGE
4/4

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OAK POINT
CHIROPRACTIC

3800 Watt Avenue, Suite 120 Sacramento, CA 95821

Telephone: 916.484.0321 • Fax: 916.481.6830

NOTICE OF PRIVACY PRACTICES

Oak Point Chiropractic and Wellness Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please notify us for a personal conference in person or by telephone within two working days.

This notice is effective as of April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the Notice.

By way of my signature, I provide Michael P. Simmons, D.C., Steven M. Simmons, D.C., Nicolas Muhn, D.C., and Oak Point Chiropractic, with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

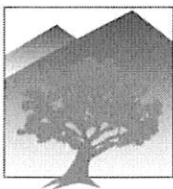
Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date



**INFORMED CONSENT TO
CHIROPRACTIC CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic and extern preceptees (final licensure pending) who now or in the future treat me while employed by, working or associated with, or serving as back-up doctor for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Printed Name of Patient

Signature of Patient or Representative

Date

Witness to Patient's Signature

Date

Translated By

Date

Names of Treating Chiropractors:
Michael P. Simmons, D.C.
Steven M. Simmons, D.C.
Nicolas Muhn, D.C.

Oak Point Chiropractic & Wellness Center
3800 Watt Avenue, Suite 120
Sacramento, CA 95821