

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	e? Patie	nt Number (office use only)		
Whom may we thank for referring you?		○ No ○ Yes When?	If so, whom?	If so, whom?		
Go	nder	Race		Ethnicity		
· · · · · · · · · · · · · · · · · · ·	Male O Female	O American Indian O Alaskan Native O	○ Asian ○ Black or African Americander ○ Other ○ White			
Birth Date (MM/DD/YYYY)		O Decline to answer		O Decline to specify		
Your Last Name		Your Social Security Number	Smoking Status (age 13 and over A Smoker Former Sm	oker		
Your First Name	***************************************	Your Middle Name (or Initial)	O Current Every Day Smoker O C O Heavy Smoker O Light Smoker			
Address			Marital Status ○ Married ○ Single ○ Divorced			
City	State/Pr	rovince ZIP/Postal Code	○ Widowed ○ Separated P	referred Language		
Home Phone	Cell Pho	ne	Spouse's Name			
Email Address	=	×	Child's Name and Age			
Emergency Contact	Emergei	ncy Contact's Phone	Child's Name and Age			
Your Occupation			Child's Name and Age	8		
Your Employer			Work Phone			
Address			May we contact you at work?	CONFIDENTIAL		
City	State/Pr	ovince ZIP/Postal Code	Preferred method of contact?	3		
Olly	Oldic/11	ovinee Zii /i ostai oode	O Home Phone O Cell Phone			
Primary Care Provider's Name			OWork Phone OEmail	띺		
Insurance Carrier		Policy Number		EALTH		
Insured's Last Name		Birth Date (MM/DD/YYYY)	Who carries this policy? ○ Self ○ Spouse ○ Parent			
Insured's First Name	red's First Name Insured's Middle Name (or Initial)			OR!		
Insured's Employer				INFORMATION		
Address						
City	State/Pr	rovince ZIP/Postal Code	Employer's Phone	Version No. 195354750 Version No. 195354750 Version No. 195354750		

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply. Location (Where does it hurt?) **Additional Complaint** Secondary Complaint Circle the area(s) on the The primary symptom that prompted me to seek care The secondary symptom that prompted me to seek care The additional symptom that prompted me to seek care illustration. "0" for current condition today is: "X" for conditions experienced in the past And are the result of (darken circle): And are the result of (darken circle): And are the result of (darken circle): O An accident or injury O An accident or injury OAn accident or injury ○ Work ○ Auto ○ Other ○ Work ○ Auto ○ Other O Work O Auto O Other A worsening long-term problem A worsening long-term problem A worsening long-term problem OAn interest in: O Wellness O Other OAn interest in: O Wellness O Other OAn interest in: O Wellness O Other Onset (When did you first notice your current Onset (When did you first notice your current Onset (When did you first notice your current symptoms?) symptoms?) symptoms?) Prior interventions (What have you done to relieve Prior Interventions (What have you done to relieve Prior Interventions (What have you done to relieve the symptoms?) the symptoms?) the symptoms?) O Prescription medication O Acupuncture O Prescription medication O Acupuncture O Prescription medication O Acupuncture Over-the-counter drugs O Chiropractic Over-the-counter drugs O Chiropractic Over-the-counter drugs O Chiropractic O Homeopathic remedies ○ Massage O Homeopathic remedies O Homeopathic remedies ○ Massage O Physical therapy Olce O Physical therapy Olce O Physical therapy ○ lce O Surgery ○ Heat O Surgery O Heat O Surgery O Heat O Other Other __ O Other 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 Have Had Have Had Have Had Have Had Have Had Have NDNE () O O Arthritis O O Neck pain O Osteoporosis O O Scoliosis O OBack problems O O Hip disorders O Foot/ankle pain O Shoulder problems O Elbow/wrist pain O TMJ issues O O Poor posture O Knee injuries initials ____ b. Neurological NDNE () Had Have Had Have Had Have O O Dizziness O Depression OHeadache O Pins and **O** Numbness Initials _ c. Cardiovascular NONE () Had Have O High blood O O Poor circulation O O Angina O Low blood O High cholesterol O Excessive Patient name bruising Initials ____ pressure pressure

Had Have

Had Have

O Food sensitivities O O Heartburn

O O Hay fever

O Chronic ear

O Acne

infection

O O Emphysema

Had Have

O O Ringing in ears O O Hearing loss

Had Have

Had Have

O Shortness

O Constipation

O Hair loss

d. Respiratory

Had Have

e. Digestive

f. Sensory

Had Have

g. Skin

O O Anorexia/bulimia O

O O Blurred vision

O O Skin cancer

Had Have

O O Apnea

OUlcer

O Psoriasis

Patient Number
(office use only)

Doctor's Initials

Oak Point Chiropractic

NDNE ()

NDNE ()

NONE (

initials

NONE ()

Initials _

Initials

Initials

O Pneumonia

O Diarrhea

O Rash

0

O Loss of smell O O Loss of taste



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Incastal History Place identify part and state Place identified	Had Have Had Have Had Have O O Hypoglycemia	a O O Frequent O O Swollen gla	lands O O Low energy	Patient name
Past Personal, Family and Social History Past Control Past Contro	Had Have Had Have Had Have O Bedwetting	Had Have Had Have O Prostate issues O Erectile	O OPMS symptoms	
Past Personal, Family and Sacial Vistory Please identify your gast feeth history, including accidents, injuries, illnesses and freatments. Please complete each section fully. 4. Illnesses Check the illnesses you have head in the past of Have now. Institute A RIDS A RIDS Toubroulosis Appendix emoyal A		○ ○ Fatigue ○ ○ Sudden we	eight O Weakness	All other systems negative
Some health issues are hereditary. Tell Oak Point Chiropractic about the health of your immediate family members. Relative Age (If living) State of health Illnesses Age at death Cause of death Natural Illness Na	Please identify your past health history, including accidents, injuries, illnesses Check the illnesses you have Had in the past or Have now. Had Have AIDS Alcoholism Alcoholism Allergies Areriosclerosis Cancer Chicken pox Diabeles Epilepsy Glaucoma Goiter Gout Heart disease Hepatitis HIV Positive Malaria Measles Multiple Sclerosis Mumps Rheumatic fever Had a fractured or or new Sexually transmitted disease Been knocked unce	5. Operations Surgical interventions, which may or may not have included hospitalization. Appendix removal Bypass surgery Cancer Cosmetic surgery Elective surgery Hysterectomy Pacemaker Spine Tonsitlectomy Vaseetomy Other: Used a crutch or other supponsoious Received a tattoo	6. Treatments Check the ones you've received in the Past or are receiving Currently. Past Currently Acupuncture Antibiotics Birth control pills Blood transfusions Chemotherapy Chiropractic care Dialysis Herbs Homeopathy Hormone replacement Inhaler Massage therapy Medications (Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals)	
Mother Good Prov Natural Illness Father Good Prov Good Prov Natural Illness Father Good Good Good Good Good Good Good Goo		of your immediate family members.		
11. Social History Tell Oak Point Chiropractic about your health habits and stress levels. Alcohol use O Daily O Weekly How much? Prayer or meditation? O Yes O No	Mother	ilinesses	Natural Iliness	
	11. Social History Tell Oak Point Chiropractic about your health habits and stress levels.			
Tobacco use ODaily OWeekly How much? Financial peace? OYes ONO Doctor's Initials Exercising ODaily OWeekly How much? Vaccinated? OYes ONO	Coffee use	Job pressu Financial p Vaccinated Mercury fi	ure/stress? Yes No peace? Yes No d? Yes No illings? Yes No	Doctor's Initials Oak Point Chiropractic

v does this condition cur	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect	Patient name
Sitting ————	$\overline{}$	- 0-	- 0-	<u> </u>	Grocery shopping ————		<u> </u>	- 0-	<u> </u>	
		0	- 0-	\multimap	Household chores ————	0	- 0-		<u> </u>	(office use only)
Standing ———	•	•	<u> </u>	— O	Lifting objects -		_	<u> </u>	<u> </u>	*
Walking —		_	<u> </u>	\multimap	Reaching overhead		252		<u> </u>	
Lying down ————	_	_	<u> </u>	-	Showering or bathing ———	(1.00m)	10.000	<u> </u>	<u> </u>	
Bending over ———	-	_	- 0-	\multimap	Dressing myself —————	_	100	<u> </u>	— O	
Climbing stairs ———			<u> </u>	—O	Love life —————			- 0-	<u> </u>	
Using a computer ——			- 0-	\multimap	Getting to sleep -			<u> </u>	— ○	
Getting in/out of car —	15 - 2	350	-	- 0	Staying asleep	100	57.52	<u> </u>	<u> </u>	
Driving a car ———	10 -0 1		1000	<u> </u>	Concentrating —			<u> </u>	<u> </u>	
Looking over shoulder -	5 <u>~</u> 0		_	1/10-0-00	Exercising —	_	_	<u> </u>	<u> </u>	
Caring for family ———	 0-	_0_	- 0-	$\overline{}$	Yard work ———	 0-	- 0-	<u> </u>	— O	
				_	16. What is your p					
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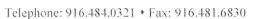
Patient (or Guardian's) signature

Date (MM/DD/YYYY)

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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