Wheeler Family Chiropractic

Date: _____

Doctor _____

File Number _____

Name _____ Preferred Name _____

Address _____

City _____ State_____ ZIP _____

Phone No. (Home) _____ (Cell) _____

Is it okay to contact you at work? ☐ No ☐ Yes Work No. _____

E-mail address _____ @_____._____

Birth date ____/____/____ Age _____

Occupation _____ Employer _____

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic partner

Spouse's name _____ Phone No._____

Children's names and ages _____

Do you have any pets? ☐ No ☐ Yes If yes, please tell us what kind(s) _____

Emergency contact: Name _____

Relationship _____ Phone _____

Favorite hobbies or interests _____

What Brings You Here?

Have you ever had chiropractic care before? ☐ No ☐ Yes

If yes, please tell us the doctor's name _____

Were you please with your care? ☐ No ☐ Yes

How did you find out about our office? _____

Is this appointment related to ☐ Work ☐ Sports ☐ Auto ☐ Personal injury ☐ Other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone _____

Are you receiving care from other health professionals? ☐ No ☐ Yes

If yes, please name them and their specialty _____

Please list any drugs, medications, vitamins, herbs, homeopathies/other you are taking _____

_____

Height: _____' _____" Weight _____ Are you pregnant? ☐ No ☐ Yes If yes, what month? _____

For Office use

X-rays

Cerv _____

L-Lat _____

L-AP _____

Insurance Company _____ Insured ID# _____

Address _____City _____ State_____ Zip _____

Phone (_____) _____ - _____ Policy# _____ SS# _____-_____-_____

Secondary Insurance _____ Address_____

City _____ St _____ Zip _____ Phone (_____) _____-_____

Type of Case Health Ins _____ Medicare _____ Medicare w/Supp _____ W/C _____ PI _____

DX _____, _____, _____, _____. Onset _____/_____/_____

Current Health

What are your most pressing health concerns? _____

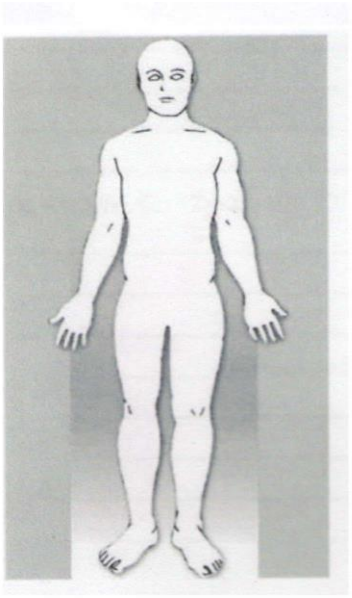
_____

_____

For how long? _____

Is it… ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Can't say

Where is the problem? Please us the illustration and lines below to explain.



☐ Front _____

_____

_____

_____

_____

_____

☐ Back _____

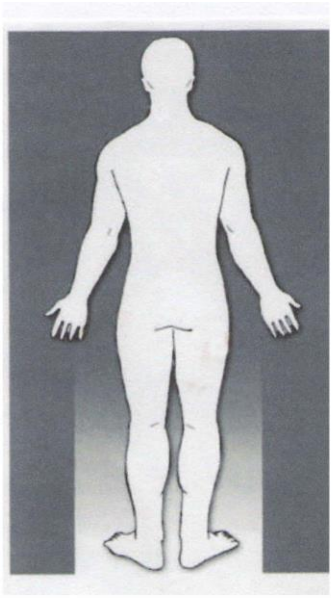
_____

_____

_____

_____

_____



Do you have… ☐ Pain ☐ Numbness ☐ Tingling ☐ Aches

Is your pain… ☐ Sharp ☐ Dull ☐ Throbbing ☐ Constant ☐ Intermittent

Are your symptoms affected by… ☐ Sitting ☐ Standing ☐ Walking

☐ Bending ☐ Lying down ☐ Weather

Please explain _____

_____

_____

Do you feel… ☐ Cramps ☐ Burning ☐ Other _____

☐ Swelling ☐ Stiffness

Do your symptoms interfere with… ☐ Work ☐ Sleep ☐ Play

☐ Day-to-day activities ☐ Other _____

Please explain _____

_____

_____

On a scale of 1-10 (1 least, 10 most), please rate the severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Do you have, or have you had, any of the following *(please check all that apply)*

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Rheumatic fever	☐ Smallpox
☐ Pleurisy	☐ Polio	☐ Chickenpox	☐ Thyroid disease	☐ Diabetes
☐ Epilepsy	☐ Cancer	☐ Depression	☐ Whooping cough	☐ Anemia
☐ Eczema	☐ Measles	☐ Arthritis	☐ Heart disease	☐ Rashes

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you use…	☐ Coffee	☐ Tea	☐ Artificial sweeteners	☐ Sugar
	☐ Alcohol	☐ Cigarettes	☐ Recreational drugs	

Have you ever suffered from *(please check all that apply)*

☐ Neck pain	☐ Stuffy nose	☐ Discolored urine
☐ Low back pain	☐ Allergies	☐ Gas/bloating after meals
☐ Headaches	☐ Fainting	☐ Heartburn
☐ Migraines	☐ Weight loss	☐ Colitis
☐ Arm/back/tingling	☐ Poor appetite	☐ Irritable bowels
☐ Shoulder pain	☐ Excessive appetite	☐ Black or bloody stools
☐ Hand pain/tingling	☐ Nervousness	☐ Constipation
☐ Leg pain/tingling	☐ Confusion	☐ Hemorrhoids
☐ Jaw pain	☐ Depression	☐ Liver problems
☐ Chest pain	☐ Dental problems	☐ Stroke
☐ Lung problems	☐ Excessive thirst	☐ Paralysis
☐ Heart problems	☐ Frequent nausea	☐ Tingling
☐ Abnormal blood pressure	☐ Vomiting	☐ Numbness
☐ Irregular heartbeat	☐ Prostate problem	☐ Fatigue
☐ Ankle swelling	☐ Breast pain/lump	☐ Dizziness
☐ Cold extremities	☐ Cramps	☐ Loss of sleep
☐ Blurred vision	☐ Painful urination	☐ Difficulty hearing
☐ Vision problems	☐ Bladder trouble	☐ Ear pain
☐ Difficulty breathing	☐ Excessive urination	If applicable, date of last menstrual period _____

Past injuries can affect present health *(please check all that apply)*

☐ Falls/accidents	☐ Head injuries	☐ Fights	☐ Sports injuries
☐ Broken bones	☐ Discoloration	☐ Spinal tap	☐ Surgery
☐ Traction	☐ Use(d) a cane or walker	☐ Extensive dental work	☐ Dental appliances
☐ Knocked unconscious			

If yes to any of the above, please describe _____

_____

_____

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress or vertebral subluxation is? ☐ No ☐ Yes

If yes, please describe _____

_____

Do any friends or relatives see chiropractors? ☐ No ☐ Yes

If yes, do they use chiropractic for… ☐ Health maintenance/optimization ☐ Health problems ☐ Both

Are you seeking chiropractic for… ☐ Health maintenance/optimization ☐ Health problems ☐ Both

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you would like us to know about you? ☐ No ☐ Yes

If yes, please tell us: _____

_____

_____

Doctors Notes: _____

1 – (Mv, Wk, Sp, S/F, Hm) (Yr), (DC Y / N)

2 – (Mv, Wk, Sp, S/F, Hm) (Yr), (DC Y / N)

3 – (Mv, Wk, Sp, S/F, Hm) (Yr), (DC Y / N)

4 – (Mv, Wk, Sp, S/F, Hm) (Yr), (DC Y / N)

5 – (Mv, Wk, Sp, S/F, Hm) (Yr), (DC Y / N)

Other -

Financial Responsibility

Who is responsible for payments? _____

How will you pay for your care? ☐ Cash ☐ Check ☐ Credit Card

The above is accurate to the best of my knowledge.

_____ _____

(signature) I, parent/guardian, give permission for minor's care. (date)

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Congratulations for having chosen the safest and most natural health care program in the world: Chiropractic.

In accordance with California law this notice is to inform you as a patient of the material risks of undergoing chiropractic care. Material risk means that there are known inherent risks from a particular treatment. Since the literature is vague and sometimes biased it is not absolutely known that there are any material risks from chiropractic care in general.

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 most countries. Chiropractic has the lowest incidence of any reported side effects of any other healthcare profession. This is 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 postural balancing.

In the history of chiropractic, there has been an extremely rare rate of occurrence for muscle spasms, tightness, and rib fracture and disc injuries.

Also, there have been medical reports of a possible connection to stroke although unconfirmed in the literature. In fact, 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 said 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 University of Toronto said "patients had already damaged the artery before seeking help from either medical doctor or a chiropractor

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 from 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, low 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.

_____ _____ _____/_____/_____

Print Name Patient Signature (Legal Guardian) Date

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 at **Family Chiropractic** we may use or disclose personal and health related information about in the following ways:

*Your protected health information, including your clinical records, may be disclosed to another health care provider of 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 services provided to you.

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

You have a right to equal restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office. Your name, address telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternatives means or an alternative locations. We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

*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.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlines above will only be made upon your written authorization. If you provide and authorization of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may be no longer be protected by the federal privacy rules. We normally provide information about your health 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 specific form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment or your health information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient files 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 changes in our privacy notice will apply for all of your health information in our files. If you have a complaint regarding our privacy notice, out privacy practices or any aspect of our privacy activities you should direct your complaint to:

If you would like further information about or privacy policies and practices please contact: Family Chiropractic: 5482 Complex Street, Suite 101, San Diego, CA 92123.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services . If you choose to lodge a complaint with this office or with the Secretary your call will continue and your will no be disadvantaged by this office or our staff in any manner whatsoever. This notice is effective as of April 2003. This notice, and any alterations of amendments made hereto will expire seven years after the date upon with the record was created,. My signature acknowledges that I have received and copy of this notice.

Name (please print)	Signature	Date

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

Personal representative (please print)	Personal representative Signature	Date	Relation to patient

Patient Authorization regarding chiropractic care being provided in an "open-door" adjusting environment

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involved the doctor moving from patient care area to patient care area and as a result patients are within sight of on another and some ongoing routine details of care are discussed within earshot of another patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examination or presenting reports of findings. These procedures are complete in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that these kinds of matters related in an "open-door" environment are incidental matters. In the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an open-door adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from **Family Chiropractic** or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (please print)	Signature	Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the changes in our procedures to be complete.