

# CARE Chiropractic Registration And History

## Patient Information

Name \_\_\_\_\_ Gender M  F  Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_  Work Phone \_\_\_\_\_  Mobile Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed Spouse's Name \_\_\_\_\_ Number of Children \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

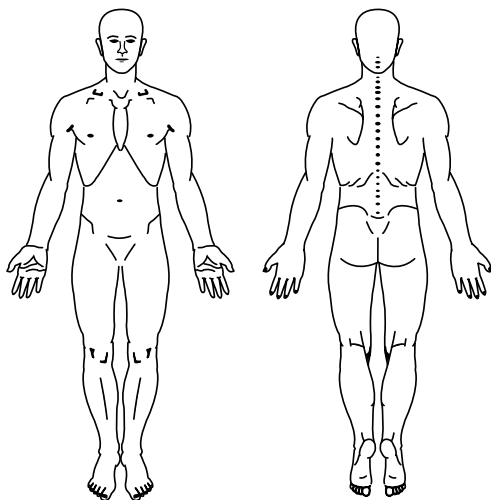
Have you ever been to a chiropractor before? If yes, which doctor? \_\_\_\_\_

## Patient Condition

Reason for visit \_\_\_\_\_  Work Related  Vehicle Accident

When did your symptoms appear? \_\_\_\_\_ Cause of Symptoms? \_\_\_\_\_

Using the diagram below, mark the areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). Then, please answer the questions to the right by circling the number that best represents your pain, where **1 is no pain and 10 is pain as bad as you can imagine**.



Scars: Use the diagrams to the left to draw any scars (major or minor) that you have.

Rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

**1 2 3 4 5 6 7 8 9 10**

Rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

**1 2 3 4 5 6 7 8 9 10**

Rate your pain by circling the one number that best describes your pain on AVERAGE for the past WEEK.

**1 2 3 4 5 6 7 8 9 10**

Type of Pain  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning

Tingling  Cramps  Stiffness  Swelling  Other \_\_\_\_\_

How often do you have this pain?  Once in awhile (0-25% of the time)  Sometimes (26-50% of the time)

Most of the time (51-75% of the time)  All the time (76-100% of the time)

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Lying Down  Bending

Other \_\_\_\_\_

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  None

Other \_\_\_\_\_

Do you have any other health concerns? \_\_\_\_\_

## Family and Patient History

Any familial history of  Arthritis  Blood disorder  Cancer  Diabetes  Epilepsy  Genetic Predisposition  
 Other \_\_\_\_\_

Date of last Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

### Past or Present illness/conditions

- |   |  |   |  |  |   |   |
|---|--|---|--|--|---|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Herniated Disk              | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Polio                | <input type="checkbox"/> STD'S              |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Herpes                      | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Prostate Trouble     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Bullimia            | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Thyroid Trouble    |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Goiter         | <input type="checkbox"/> HIV/ARC                     | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Gonorrhea      | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Gout           | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Scarlet Fever        | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Cirrhosis/Hepatitis | <input type="checkbox"/> Hay Fever      | <input type="checkbox"/> Low Blood Pressure          | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Measles                     | <input type="checkbox"/> Pinched Nerve       | <input type="checkbox"/> Sinus Trouble        | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Bone Fracture      | <input type="checkbox"/> Dislocated Joints   | <input type="checkbox"/> Hernia         | <input type="checkbox"/> Mental/Emotional Difficulty | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Spinal Disc Disease  | <input type="checkbox"/> _____              |

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

### WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### MISCELLANEOUS

- Smoking \_\_\_\_\_ Packs/Day  
 Alcohol \_\_\_\_\_ Drinks/Week  
 Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day  
 Water \_\_\_\_\_ Glasses/Day  
 High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_  
 Sleep \_\_\_\_\_ Hours/Night, Position \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

### MEDICATIONS

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### VITAMINS/HERBS/MINERALS

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### ALLERGIES

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### SURGERIES/HOSPITALIZATIONS

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Insurance Information - Please provide a copy of your insurance card(s)

Primary \_\_\_\_\_ Name of insured \_\_\_\_\_  
 Secondary \_\_\_\_\_ Name of insured \_\_\_\_\_

## Authorization For Treatment

I have answered the above questions accurately to the best of my knowledge. I authorize Dr. Namsa to perform examination and treatment procedures on me that are deemed appropriate for my condition.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**CARE Chiropractic**  
**2858 Stevens Creek Blvd., Suite 208**  
**San Jose, CA 95128**  
**(408) 780-8440**  
**Notice of Privacy Practices**

**Disclosure of Your Health Care Information**

**Treatment**

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

**Payment**

We may disclose your health information to a billing service and your insurance provider for the purpose of payment and/or health care operations.

**Workers' Compensation**

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency.

**Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administrative Proceedings**

We may disclose your health information in the course of any administrative or judicial proceeding.

**Marketing**

We may contact you for marketing purposes or fundraising purposes.

For Example:

*"As a courtesy to our patients, it is our policy to call your home in the event of a missed appointment to notify you and reschedule your appointment. If you are not at home, we will leave a message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your missed appointment along with a request to call our office and reschedule and to inform you if you need to cancel or reschedule any of your future appointments to please give a minimum of 24 hours notice."*

*"It is our practice to participate in or host events to raise awareness, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Network \_\_\_\_\_ sponsored fund-raising events."*

**Change of Ownership**

In the event that CARE Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that CARE Chiropractic is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.

- You have a right to request that CARE Chiropractic amend your protected health information. Please be advised that CARE Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by CARE Chiropractic
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

CARE Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, CARE Chiropractic is required by law to comply with this Notice.

CARE Chiropractic 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 any questions and/or complaints regarding this notice or if you want more information about your privacy rights, please contact: Dr. Namsa by calling the office at (408) 780-8440. If the doctor is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**CARE Chiropractic**  
**2858 Stevens Creek Blvd., Suite 208**  
**San Jose, CA 95128**  
**(408) 780-8440**  
**Financial Policy**

**INSURANCE**

It is the policy of this office that you pay for your patient portion (copay) at the time of visit. If you have health insurance that you believe may cover chiropractic in this office, we will verify your insurance coverage for you. Once your eligibility and coverage is determined we will file all insurance claims for you to the extent that your policy permits. Your health insurance company will then send you a statement (Explanation of benefits) explaining what services were paid for on their behalf, as well as any amount you are responsible for (co-insurance, deductible).

**NON-INSURED**

We request 100% of the first visit be paid at the time of the first visit. All future visits must be paid for at the time of service.

If you have Kaiser Permanente but do not have chiropractic coverage, we offer a 25% discount off our normal fees.

We offer affordable cash options to uninsured patients. If your financial situation requires special arrangements, please inform us and we will do our best to accommodate you.

**AUTOMOTIVE INSURANCE**

If your visit is due to an automobile accident, we will work with your car insurance and file all claims for you.

**CANCELLATION/MISSED APPOINTMENT POLICY**

We ask that you notify us at least 24 hours prior to your scheduled appointment of any changes or cancellations. If prior notification is not given, you will be charged **\$35.00** for the missed appointment.

We do, of course, understand that unavoidable issues come up and will do our best to work with you in case of an emergency.

**IT MUST BE UNDERSTOOD:**

This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged. Therefore, the clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

*I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.*

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_