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 _____

Martial Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed Spouse's Name _____ Number of Children _____

Emergency Contact _____ Relationship _____ Phone _____

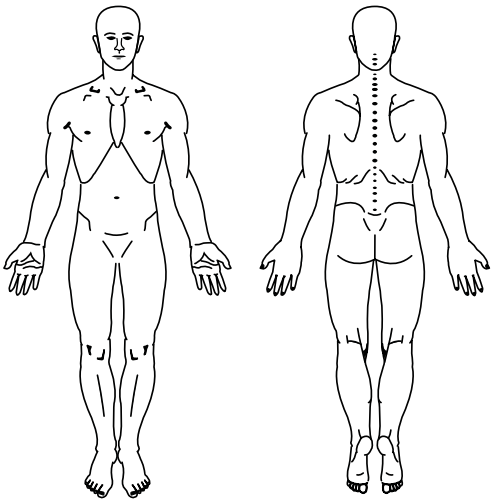
Have you ever been to a chiropractor before? If yes, which doctor? _____

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

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

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

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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.

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.

WORKERS' COMPENSATION

Chiropractic services are covered by Workers' Compensation law, and you should be covered 100%, as long as your employer is aware you were injured on the job, you have completed the required papers with your employer, your employer has no objection to your receiving care here, and is covered by Workers' Compensation Insurance. You are responsible for non-covered items such as supplements and supports that are not a direct result of the accident. These items are to be paid for at the time they are received.

AUTOMOTIVE INSURANCE

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

IT MUST BE UNDERSTOOD:

1. 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.
2. If you have more than one insurance and would like to bill it, we will supply you with a copy of our insurance billing to use in billing your second insurance.

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: _____