Sorrento Valley Chiropractic

5440 Morehouse Drive, Suite 1700 · San Diego, CA 92121 · (858) 455-7654

Confidential Patient Information

Please complete all fields. Your information is kept strictly confidential.

PATIENT INFORMATION

Full Name | Today's Date

Birth Date | Age | Sex

Cell Phone | E-mail

Street Address

City | State | ZIP Code

EMPLOYMENT & EMERGENCY CONTACT

Employer | Occupation

Marital Status (M / S / W / D) | Emergency Contact | Emergency Phone

TODAY'S VISIT

What brings you in today? Where is the pain, and how did it start?

How long has this been going on? | Is it getting better, worse, or staying the same?

Primary care physician | Past chiropractic care? When?

This visit is a result of: ❑ Auto Accident ❑ Work Injury ❑ Chronic Problem ❑ New Injury ❑ Unknown

Whom may we thank for referring you?

INSURANCE

Insurance Company | Policy / Member # | Group #

Policy Holder (if not you) | Relationship | Secondary Insurance / HRA / HSA

FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Sorrento Valley Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company, and any amount authorized to be paid directly to Sorrento Valley Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, all fees for professional services rendered to me will be immediately due and payable.

Patient (or Guardian) Signature | Date

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Present Complaints

Please check all that apply and fill in the blanks where appropriate.

Name Date

1. Present complaint

2. Character of the pain (check all that apply): ❑ Sharp / Stabbing ❑ Aches ❑ Dull / Soreness ❑ Weakness ❑ Throbbing ❑ Numbness ❑ Shooting ❑ Burning ❑ Tingling ❑ Gripping / Constricting

3. How often is it present? ❑ Constant (76–100%) ❑ Frequent (51–75%) ❑ Occasional (26–50%) ❑ Intermittent (25% or less)

4. How bad is the pain? Circle a number below (0 = no pain · 10 = unbearable):

0 1 2 3 4 5 6 7 8 9 10

5. Since it began, the pain is: ❑ Increasing ❑ Decreasing ❑ Not changing

HOW IT BEGAN

6. When did it begin (date if possible)? _____ 7. It began: ❑ After a specific incident ❑ Multiple incidents ❑ Gradually

8. Describe how it began

9. Treatment received for this condition: ❑ Surgery ❑ Spinal injections ❑ Physical therapy ❑ Back support ❑ None ❑ Other: _____

10. Treated before for this same condition? ❑ Yes ❑ No By: ❑ Chiropractor ❑ MD ❑ Therapist ❑ Other When: _____

WHAT AFFECTS IT

11. Better with: ❑ Nothing ❑ Lying down ❑ Walking ❑ Standing ❑ Sitting ❑ Movement / Exercise ❑ Inactivity ❑ Other

12. Worse with: ❑ Nothing ❑ Lying down ❑ Walking ❑ Standing ❑ Sitting ❑ Movement / Exercise ❑ Inactivity ❑ Other

WORK & ACTIVITY

13. General stress level: ❑ None ❑ Minimal ❑ Moderate ❑ Greatly stressed

14. Physical activity at work: ❑ Sedentary ❑ Light manual labor ❑ Manual labor ❑ Heavy manual labor

15. General exercise: ❑ No regular exercise ❑ Light exercise program ❑ Strenuous exercise program

16. Effect on work / daily activity: ❑ No effect ❑ Some restrictions ❑ Need limited assistance ❑ Need assistance often ❑ Significant inability to function ❑ Totally disabled

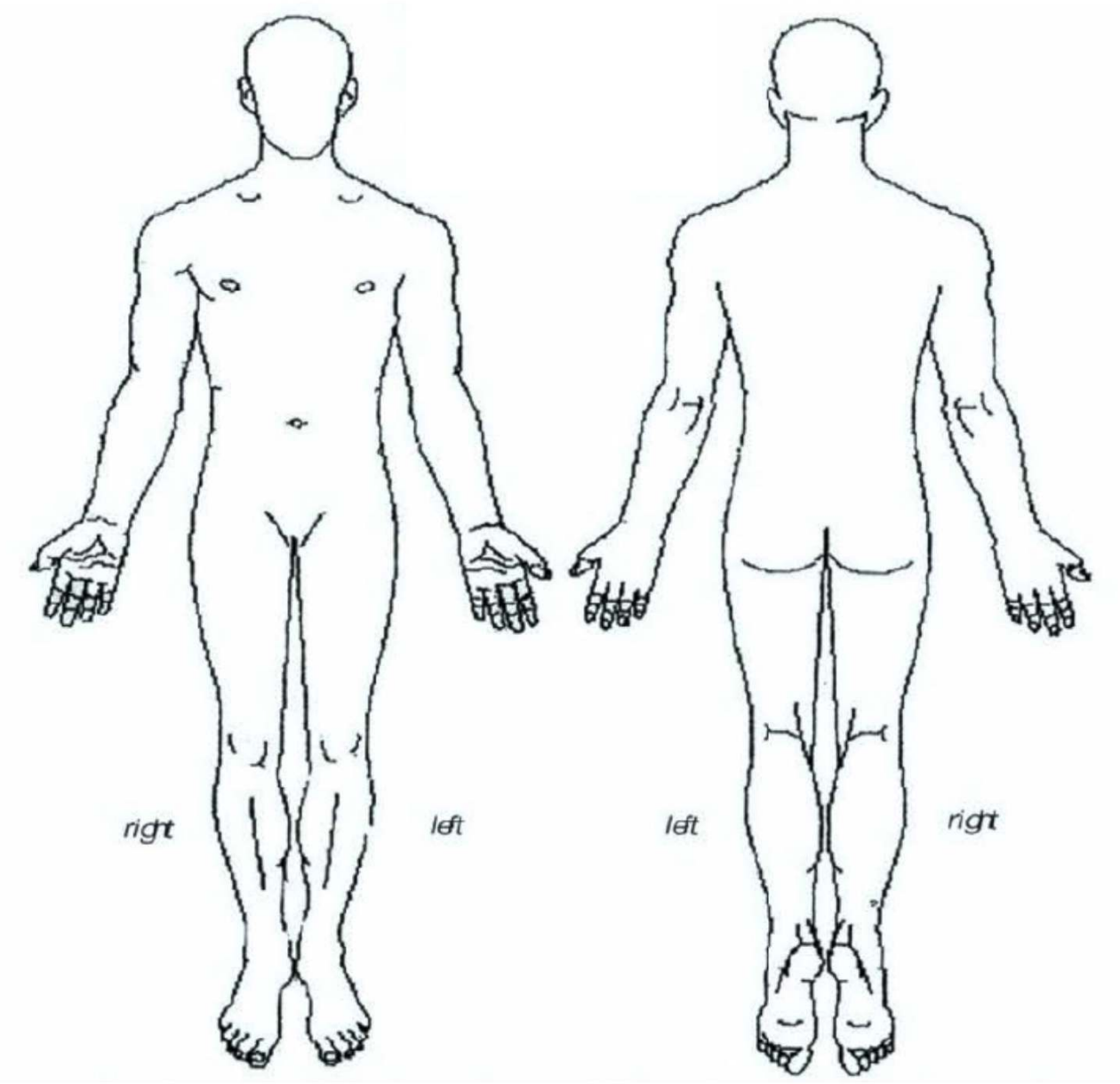
CERTIFICATION

I certify that the above information is complete and accurate to the best of my knowledge.

Patient (or Guardian) Signature Date

Present Complaints — Symptom Diagram

Mark an X on the figures wherever you have pain or other symptoms, including numbness or tingling.



FRONT **BACK**

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Patient Health Questionnaire

This form helps us make sure chiropractic care is safe and right for you. Please answer every question.

Patient Name _____ Date _____

MUSCULOSKELETAL HISTORY — check Past for previous problems, Now for current problems

PAST	NOW		PAST	NOW	
❑	❑	Neck pain	❑	❑	Hip or leg pain
❑	❑	Upper / mid back pain	❑	❑	Knee, ankle, or foot pain
❑	❑	Low back pain	❑	❑	Sciatica (radiating leg pain)
❑	❑	Headaches	❑	❑	Numbness or tingling
❑	❑	Shoulder or arm pain	❑	❑	Jaw pain (TMJ)
❑	❑	Hand or wrist pain	❑	❑	Joint swelling or stiffness

SAFETY SCREENING — have you ever had, or do you currently have, any of the following?

	YES	NO		YES	NO
Osteoporosis or osteopenia	❑	❑	Irregular heartbeat or palpitations (e.g., AFib)	❑	❑
Long-term corticosteroid use (e.g., prednisone)	❑	❑	Pacemaker or implanted defibrillator	❑	❑
A spinal fracture	❑	❑	Rheumatoid arthritis or ankylosing spondylitis	❑	❑
Cancer (past or present)	❑	❑	Connective-tissue disorder (Marfan, Ehlers-Danlos)	❑	❑
Unexplained recent weight loss	❑	❑	Diagnosed disc herniation, stenosis, or spondylolisthesis	❑	❑
Blood thinners (warfarin, Eliquis, Plavix, etc.)	❑	❑	Sudden weakness or numbness in arms or legs	❑	❑
Stroke or TIA (mini-stroke)	❑	❑	Numbness in the groin / saddle area	❑	❑
Aortic or other aneurysm	❑	❑	Recent change in bladder or bowel control	❑	❑
Dizziness or fainting when turning your head	❑	❑	Fever or infection along with your back / neck pain	❑	❑
Chest pain or pressure, especially with activity	❑	❑	A severe headache unlike any you have had before	❑	❑
Left-sided arm, neck, or jaw pain with exertion	❑	❑	Are you pregnant or possibly pregnant?	❑	❑
Shortness of breath	❑	❑			

Family history of aortic aneurysm or inflammatory arthritis? ❑ Yes ❑ No

If you answered YES to any item above, please explain: _____

INJURY & SURGERY HISTORY

Ever been in a car accident, even a minor one? ❑ Yes ❑ No If yes, date(s): _____

Significant falls, sports injuries, or broken bones? ❑ Yes ❑ No Details: _____

Any spinal surgery? ❑ Yes ❑ No Type and date: _____

Other surgeries or hospitalizations (list): _____

MEDICATIONS & GENERAL

Current medications, incl. over-the-counter pain relievers: _____

Do you use tobacco? ❑ Yes ❑ No Height: ____ ft ____ in Weight: _____ lbs

CERTIFICATION

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this office whenever I have changes in my health condition.

Patient (or Guardian) Signature _____ Date _____

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Informed Consent for Chiropractic Care

Please review this form with your doctor. Your signature confirms that your questions have been answered and that you consent to care.

Your doctor of chiropractic evaluates patients using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a short distance to a specific vertebra or bone. A number of techniques may be used to deliver the adjustment, some of which use specially designed equipment. Adjustments are usually performed by hand but may also be performed with hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations, and rehabilitative procedures.

Chiropractic treatment is one of the safest interventions available to the public, as demonstrated through clinical trials and reflected indirectly by the low malpractice insurance rates paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. A referral for further diagnosis or management to a medical physician or other provider will be suggested when warranted by your history and examination findings.

POSSIBLE SIDE EFFECTS & COMPLICATIONS

Common

- The reactions most commonly reported are local soreness or discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), and dizziness — the vast majority of which resolve within 48 hours.

Rare

- Fractures or joint injuries, in isolated cases involving underlying physical defects, deformities, or pathologies.
- Burns from certain heat or therapy modalities.
- Disc herniations.
- Cauda equina syndrome (approximately 1 case per 100 million adjustments).
- Compromise of the vertebrobasilar artery (i.e., stroke) — estimated at 1 case per 400,000 to 1 million cervical spine adjustments. A comparable association is also found when patients consult a medical doctor, and the risk is higher for those over age 45.

Please tell your doctor immediately if you have a headache or neck pain that is the worst you have ever felt.

BENEFITS, ALTERNATIVES & OUTLOOK

I understand that there are beneficial effects associated with these procedures, including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and that a referral may be necessary if a course of chiropractic care does not improve my condition.

Reasonable alternatives have been explained to me, including prescription medications, over-the-counter medications, possible surgery, and non-treatment. A summary of the concerns associated with each alternative follows:

- Long-term use or overuse of medication carries a risk of dependency; pain medication also carries a risk of gastrointestinal bleeding, among other risks.
- Surgical risks may include an unsuccessful outcome and complications such as infection, pain, reactions to anesthesia, and prolonged recovery.
- Refusing or neglecting care may lead to increased pain, restricted motion, increased inflammation, and worsening of my condition.

Neck and back pain generally improve over time; however, recurrence is common. Remaining active and positive improves your chances of recovery.

CONSENT & ACKNOWLEDGEMENT

I have read the information above regarding the risks of chiropractic care, and my doctor has verbally explained my risks (if any) and suggested alternatives where those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and the alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care, understanding any perceived risks and the alternatives to this care.

Patient (or Parent / Guardian) Signature _____ Date _____

Doctor's Signature _____ Date _____

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Notice of Privacy Practices — Acknowledgement

Please review and sign below to confirm you have received our Notice of Privacy Practices.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly;
- Obtain payment from third-party payers; and
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this office at any time at the address above to obtain a current copy.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but that if you do agree, you are bound to abide by such restrictions.

ACKNOWLEDGEMENT

Patient Name _____ Relationship to Patient (if signed by representative) _____

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below.

Date _____ Initials _____ Reason _____

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Assignment and Instruction for Direct Payment to Doctor and Health Insurance

Please complete, initial, and sign below.

RE:

Patient

Policy # / Group #

I hereby instruct and direct (insurance company)

to pay by check, made out and mailed directly to:

Sorrento Valley Chiropractic
5440 Morehouse Drive, Suite 1700
San Diego, CA 92121

If my current policy directly prohibits direct payment to the doctor, I instruct you to make the check payable to me. _____ INITIALS

For professional or medical expense benefits that are allowable and otherwise payable to me under my current insurance policy, I hereby assign payment toward the total charges for professional services rendered. **This is a direct assignment of my rights and benefits under this policy.**

I understand that insurance benefits are subject to the terms, limitations, exclusions, deductibles, copayments, and coinsurance requirements of my insurance policy. **If my insurance plan has a deductible, I understand that I am responsible for paying the deductible amount, as well as any copayments, coinsurance, non-covered services, or remaining balance not paid by my insurance company.**

This payment shall not exceed my indebtedness to the assignee mentioned above, and I agree to pay in a timely manner any balance of professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to the insurance company involved for the purpose of processing claims and obtaining payment for services rendered.

Patient (or Guardian) Signature Date