**INITIAL HEALTH STATUS**

Patient Name _____ Birthdate _____ Sex M /F

Address_____ City_____ State_____ Zip_____

Telephone (____) _____ SSN _____ Driver's Lic. # _____

Cell Phone (____) _____ Email _____

Work Phone (____) _____ Employer_____ Occupation_____

Subscriber Name _____ Subscriber SSN_____ Health Plan _____

Subscriber ID #_____ Group # _____ Spouse Name_____

Primary Care Physician _____ PCP Phone _____

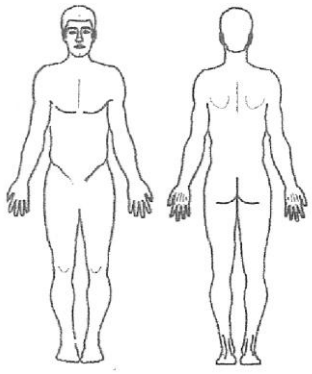
**PLEASE GIVE US DETAILS ABOUT YOUR CURRENT AREA OF PAIN:**

☐ Head ☐ Neck ☐ Upper Back ☐ Middle Back ☐ Low Back

Is this related to… ☐ Auto ☐ Work ☐ N/A

Date Problem Began_____ How Problem Began _____

**NOTE WITH AN "X" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS**



Current complaint (how you feel today):

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How often are your symptoms present?

☐ 0 - 25% (Intermittent) ☐ 26 - 50% ☐ 51 – 75% ☐ 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities?

(*e.g., work, social activities, household chores)*

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to complete tasks.

**HAVE YOU HAD SPINAL X-RAYS, MRI, OR CT SCAN TAKEN?** ☐ Yes ☐ No

Date(s) taken: _____ What facility? _____

What areas were taken? _____

**PLEASE DESCRIBE YOUR OVERALL CURRENT LEVEL OF HEALTH:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight: _____

Please check all of the following that apply to you:

☐ Marked Morning Pain/Stiffness ☐ Prostate Problems ☐ Diabetes ☐ Corticosteroid Use

☐ Pain regardless of Position or Rest ☐ Menstrual Problems ☐ High Blood Pressure ☐ Birth Control Use

☐ Abnormal Weight Gain/Loss ☐ Urinary Problems ☐ Epilepsy/Seizures ☐ Recent Fever

☐ Numbness in Groin/Buttocks ☐ Dizziness/Fainting ☐ Osteoporosis ☐ Pain at Night

☐ Currently Pregnant, _____ weeks (#) ☐ Stroke (date) _____ ☐ Cancer/Tumor _____

☐ Surgeries _____

☐ Other Health Problems _____

Family History: ☐ Cancer ☐ Diabetes ☐ Heart Problems/Stroke ☐ High Blood Pressure ☐ Rheumatoid Arthritis

What services provided by this office interest you? (please mark all that apply)

☐ Injury prevention ☐ Weight management ☐ Spinal and body alignment/posture

☐ Treatment for pain ☐ Wellness care ☐ Strengthening and stamina exercise

☐ Nutritional genetic testing ☐ Nutritional counseling ☐ Patient education workshops

If you are new to this office, how did you hear about us? ☐ Newspaper or phone book ☐ Insurance provider list

☐ Friend/family (name): _____ ☐ Other (specify): _____

If you were referred by a friend or family member, may we send them a thank you note? ☐ Yes ☐ No

*I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician if necessary.*

Patient Signature _____ Date _____

Describe your current pain/symptoms:
☐ Sharp/stabbing ☐ Dull ☐ Aches ☐ Soreness ☐ Tingling ☐ Gripping
☐ Throbbing ☐ Weakness ☐ Numbness ☐ Shooting ☐ Burning ☐ Other _____

Since it began, is your problem: ☐ Improving ☐ Getting worse ☐ No change

What makes the problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing
☐ Inactivity/rest ☐ Sitting ☐ Movement ☐ Exercise ☐ Other _____

What makes the problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing
☐ Inactivity/rest ☐ Sitting ☐ Movement ☐ Exercise ☐ Other _____

What treatment have you had for this condition in the past? ☐ Chiropractic ☐ Massage
☐ Medications ☐ Injections ☐ Surgery ☐ Other _____

Are you currently receiving care with another health practitioner for this condition? ☐ Yes ☐ No
Date Started: _____ Procedure: _____
Doctor/Therapist Name: _____ Helping?: _____

What significant past accidental injuries have you had? ☐ None
☐ Concussions ☐ Head injuries ☐ Broken bones ☐ Slip and falls ☐ Auto accidents/work injuries
Injury: _____ App. date: _____Recurring/Residual effects: _____

Describe your job requirements: ☐ Mainly sitting ☐ Light labor ☐ Heavy labor
How many hours per day do you use a computer at work or home? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5
How many hours per day do you ride in a car or other vehicle? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5
How many hours per day do you watch television? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

Tobacco use: ☐ presently ☐ in the past
Alcohol use: ☐ presently ☐ in the past
Drug Dependence: ☐ presently ☐ in the past
Explain: _____

How often do you exercise? ☐ daily ☐ 5-6x/week ☐ 3-4x/week ☐ 1-2x/week ☐ I don't exercise
How long do your workouts last? ☐ > 1 hour ☐ 30 – 60 min ☐ < 30 min. ☐ N/A

What are your exercise activities? (mark all that apply) ☐ N/A
☐ Bicycle/stationary bike ☐ Walking ☐ Resistance bands ☐ Weight lifting ☐ Group exercise class
☐ Running/treadmill/climbing ☐ Stretching ☐ Swimming ☐ Yoga/Pilates ☐ Other _____

How would you describe your overall diet?
☐ I eat mostly plant-based foods (i.e. fruits, vegetables, and grains)
☐ I eat mostly meats and starches with very few fruits and vegetables
☐ I eat a relatively balanced diet

Describe your current eating pattern.
☐ Most of the time, I eat 3 or more meals per day
☐ I often skip meals
☐ I do not have a regular eating pattern

Describe your stress level: Less 0 1 2 3 4 5 6 7 8 9 10 More

Which do you feel is your primary stress? ☐ PHYSICAL ☐ CHEMICAL ☐ EMOTIONAL Explain: _____

If you are presently taking any type of medications or nutritional supplements *(e.g., vitamins, minerals, herbs, amino-acids, fish oils, antioxidants, etc.)*, please provide **(1)** a list of the type(s) you are taking, **(2)** the reason(s) you are taking them, and **(3)** the source that recommended them. ☐ N/A

Patient Signature: _____ Date: _____

**Lifestyle Chiropractic & Wellness**
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----------PLEASE DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY----------
Patient Objectives: ☐ Temporary relief ☐ Permanent relief ☐ Prevention ☐ Maintenance ☐ Wellness

# INFORMED CONSENT DOCUMENT

**Patient Name**: _____ **Date of Birth:** _____

**TO THE PATIENT:** Please read this entire document prior to signing it. It is important that you understand the information contained herein. If anything is unclear, please consult the staff or doctor before signing this document.

**The Nature of the Chiropractic Adjustment**
The primary treatment used by a doctor of chiropractic is spinal manipulative therapy. The doctor will perform the procedure manually or with a mechanical instrument. The adjustment may cause movement in the joints emitting an audible noise, similar to the sound of cracking knuckles.

**The Procedures Concerning Analysis, Examination, and Treatment**
As a part of the analysis, examination, and treatment, the following procedures are available and may be utilized by your doctor:

- Spinal Manipulative Therapy
- Range of Motion Testing
- Muscle Strength Testing
- Ultrasound
- Palpation
- Orthopedic Testing
- Postural Analysis
- Hot/Cold Therapy
- Vital Signs
- Basic Neurological Testing
- EMS
- Radiographic Studies

**The Material Risks Inherent in a Chiropractic Adjustment**
Equivalent to any healthcare procedure, certain complications may arise during chiropractic manipulation and therapy. Examples of complications include the following: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Commonly, patients will feel stiff and sore following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care. However, the responsibility lies with the patient to inform the doctor of any conditions that could go unnoticed.

**The Probability of the Aforementioned Risks Occurring**
Fractures are rare occurrences and generally result from some underlying weakness of the bone for which the doctor checks during examination (including a review of the patient's history) and radiographic studies. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. Other complications are also generally described as rare.

**The Availability and Nature of Other Treatment Options**
Other treatment options for the patient's condition may include the following: over-the-counter pain relievers, rest, medical care, prescription drugs, hospitalization, and surgery. If one of the other treatment options is used, the patient should be aware that risks and benefits apply to such options.

**The Risks of Suspending or Postponing Care**
Remaining untreated may result in the formation of adhesions and reduction of mobility. Refraining from pursuing treatment may also result in further declension of health. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

## DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE TERMS OF THIS DOCUMENT.

**I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor at *Lifestyle Chiropractic & Wellness* and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment. Having been informed of the risks, I hereby give my consent to that treatment.**

| _____ | _____ | _____ |
|---|---|---|
| ***Patient's Name*** | ***Patient's Signature (Guardian's Signature If Patient Is a Minor)*** | ***Date*** |
| _____ | _____ | _____ |
| ***Doctor's Name*** | ***Doctor's Signature*** | ***Date*** |

# NOTICE OF PRIVACY PRACTICES

**Patient Name:** _____

**TO THE PATIENT:** This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

**We may share your health information to:**

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Do research
- Discuss your case with family
- Include you in care classes
- Thank you for referring other patients

**We may use your health information for:**

- Reporting to law officials
- Court hearing and filings
- Reporting to worker's compensation
- Health and safety reasons
- Reporting victims of abuse

**You have the right to:**

- Request a copy of your health record
- Amend your protected health information
- Ask us to limit the information we share
- Request a list of persons with whom we share your health information
- Request confidential communications
- Advise our staff if you believe your privacy rights have been violated

*These privacy practices are effective October 2014.*

We may recommend you use, as a part of our treatment program, one or more nutritional supplements. We recommend this supplement or these supplements because we believe your health will benefit from your use of them. We want you to know that, because of our belief in the integrity and effectiveness of these supplements, we are a distributor of these products and, in that role, we may receive a commission from your purchase of these supplements. Please ask to speak with us if you have any concerns about our recommendations in light of this information. For further information please contact the front desk.

**EMAIL AND SOCIAL MEDIA DISCLAIMER**

Lifestyle Chiropractic & Wellness does not have an email address that is checked regularly and therefore will not be held liable for unanswered emails. For your protection, we also ask that you refrain from sending emails or posting information on social media containing personal health information as our health professionals will not respond.

**RELEASE OF LIABILITY**

Lifestyle Chiropractic & Wellness requests your permission to use you in any audio, video, and/or photography for the purposes of promoting Lifestyle Chiropractic & Wellness through any type of media including, but not restricted to websites, print, blogs, social networking, etc. This permission will be granted without restriction, and Lifestyle Chiropractic & Wellness will be held harmless from any claim, lawsuit, or further liability concerning the types of media mentioned above. Be assured, no personal health history or contact information will be divulged unless specifically authorized by you.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices, or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, DISCLAIMER AND RELEASE OF LIABILITY**

*You may refuse to sign this document.*

**I have read, or have had read to me, the above explanation. I have discussed it with the staff at *Lifestyle Chiropractic & Wellness* and have had my questions answered to my satisfaction. By signing this document, I grant the above mentioned permission to Lifestyle Chiropractic & Wellness. Having been informed, I hereby acknowledge my rights of privacy and understand this disclaimer.**

I, _____, have received a copy of the notice of privacy practices of the above named office.

_____ _____

**Patient's Signature (Guardian's Signature If Patient Is a Minor)** **Date**

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Lifestyle Chiropractic & Wellness

2091 W. Florida Ave. Ste. 120
Hemet, CA 92545

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name**:_____ **Last Name**:_____

**Email address:** _____@_____

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

***For office use only***

Height: _____ Weight:_____ Blood Pressure:_____ /_____

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- Reporting victims of abuse

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- Request a copy of your health record
- Amend your protected health information
- Ask us to limit the information we share
- Request a list of persons with whom we share your health information
- Request confidential communications
- Advise our staff if you believe your privacy rights have been violated

*These privacy practices are effective October 2014.*

We may recommend you use, as a part of our treatment program, one or more nutritional supplements. We recommend this supplement or these supplements because we believe your health will benefit from your use of them. We want you to know that, because of our belief in the integrity and effectiveness of these supplements, we are a distributor of these products and, in that role, we may receive a commission from your purchase of these supplements. Please ask to speak with us if you have any concerns about our recommendations in light of this information. For further information please contact the front desk.

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