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Today's Date:_____ Referred By:_____

Male Female File#_____

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell:_____ Home:_____ Work: _____

Email:_____ Marital Status: S M W D

Age:_____ Social Security Number:_____

Spouse's Name:_____ Name(s) of Children:_____

Employer:_____ Occupation:_____

Emergency Contact:_____ Phone Number:_____

Is your condition due to an accident? Yes No Auto Work At Home Other Date:_____

What is the primary stressor in your life? _____

Would you like us to check your insurance benefits? Yes No (provide insurance card to front desk)

Appointment Reminders: (choose one) ____Email ____Text (Cell Phone Carrier: _____)

Have you had a fall, injury or illness that required medical attention in the past? Yes No

Please complete the following with an approximate date and brief description:

Falls / Head Injuries: _____

Hospitalizations: _____

Surgeries: _____

Auto Collisions: _____Year(s):_____

Conditions/Illnesses: _____

Allergies: _____

*

Current medications: _____

Current over-the-counter medications: _____

Current supplements: _____

Current Health History

Right handed Left Handed Height _____ Weight _____

Primary Complaint: _____ _____Right _____Left

INTENSITY – Please grade the intensity (*10=worst possible pain)*: 1 2 3 4 5 6 7 8 9 10

FREQUENCY – How often do you experience this? 0-25% 25-50% 50-75% 75-100%

WHEN did this begin? _____

HOW did it start? _____

Have you had this before? Yes No

If so, what was the intensity (1-10 w/10 being the worst)? _____ and frequency? _____

QUALITY - Describe the quality (circle all that apply):

sharp dull achy burning throbbing pins and needles stabbing shooting tingling/numbness

BETTER - What makes it feel better? _____

WORSE – What makes it feel worse? _____

Is it worse at certain times of the day or night? Morning Afternoon Evening Night All the time

Is it changing with time? Getting worse Staying the same Getting better

Does it travel/radiate to another part of your body? (circle one): Yes No Where? _____

Does it interfere with? Work Sleep Recreation Daily routine None

How does it interfere? _____

Secondary Complaint: _____ _____Right _____Left

INTENSITY – Please grade the intensity (*10=worst possible pain)*: 1 2 3 4 5 6 7 8 9 10

FREQUENCY – How often do you experience this? 0-25% 25-50% 50-75% 75-100%

WHEN did this begin? _____

HOW did it start? _____

Have you had this before? Yes No

If so, what was the intensity (1-10 w/10 being the worst)? _____ and frequency? _____

QUALITY - Describe the quality (circle all that apply):

sharp dull achy burning throbbing pins and needles stabbing shooting tingling/numbness

BETTER - What makes it feel better? _____

WORSE – What makes it feel worse? _____

Is it worse at certain times of the day or night? Morning Afternoon Evening Night All the time

Is it changing with time? Getting worse Staying the same Getting better

Does it travel/radiate to another part of your body? (circle one): Yes No Where? _____

Does it interfere with? Work Sleep Recreation Daily routine None

How does it interfere? _____

Tertiary Complaint: _____ _____Right _____Left

INTENSITY – Please grade the intensity (*10=worst possible pain)*: 1 2 3 4 5 6 7 8 9 10

FREQUENCY – How often do you experience this? 0-25% 25-50% 50-75% 75-100%

WHEN did this begin? _____

HOW did it start? _____

Have you had this before? Yes No

If so, what was the intensity (1-10 w/10 being the worst)? _____ and frequency? _____

QUALITY - Describe the quality (circle all that apply):

sharp dull achy burning throbbing pins and needles stabbing shooting tingling/numbness

BETTER - What makes it feel better? _____

WORSE – What makes it feel worse? _____

Is it worse at certain times of the day or night? Morning Afternoon Evening Night All the time

Is it changing with time? Getting worse Staying the same Getting better

Does it travel/radiate to another part of your body? (circle one): Yes No Where? _____

Does it interfere with? Work Sleep Recreation Daily routine None

How does it interfere? _____

What treatments have you already received for this?

Medications Surgery Physical therapy Acupuncture Massage Chiropractic Other: _____

Results of previous treatments: _____

Name of family doctor: _____ Name of previous chiropractor: _____

SOCIAL/FAMILY MEDICAL HISTORY (circle all that apply):

Cancer Diabetes Hypertension Heart Disease Stroke Joint Problems

Alcohol consumption # of glasses per day _____ Recovering alcoholic

Smoker # packs per day_____ History of drug abuse No alcohol Non-smoker

---

REVIEW OF SYSTEMS (circle all that apply)

CONSTITUTIONAL: weight loss fever chills weakness/fatigue

HEENT: visual loss blurred vision double vision TMJ problems hearing loss sneezing congestion sore throat

SKIN: rash itching

CARDIOVASCULAR: chest pain palpitations edema chest pressure chest discomfort

RESPIRATORY: asthma coughing shortness of breath

GASTROINTESTINAL: nausea vomiting diarrhea abdominal pain bloody stool

GENITOURINARY: burning on urination sexual function changes

NEUROLOGICAL: headache dizziness fainting numbness/tingling in arms/legs
problems with bowel control problems with urine control ataxia

MUSCULOSKELETAL: joint problems implants/pins/screws

HEMATOLOGIC: anemia bleeding bruising

LYMPHATICS: enlarged lymph nodes history of splenectomy

PSYCHIATRIC: depression anxiety

ENDOCRINOLOGIC: sweating cold/heat intolerance increase in urine decrease in urine

ALLERGIES: hives eczema rhinitis other:_____

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MOTOR VEHICLE COLLISION

please provide detailed information

Today's date:_____

Patient name: _____ Date of birth: _____

Mechanism of Injury

Date of collision: _____ Time of collision: _____ am pm

Road conditions: Dry Wet Icy Visibility: Poor Good

Were you: Driver Passenger Front Seat Rear Seat Pedestrian

Year/Make/Model of vehicle you were in: _____

Year/Make/Model of other vehicle: _____

Please describe the collision: _____

_____

What direction were you headed? North East South West Name of street: _____

What direction was other vehicle headed? North East South West Name of street: _____

Were you struck from: Front Rear Passenger side Driver side

Approximate speed of your car: _____mph Other car: _____mph

Estimated damage to your car: $_____ Estimated damage to the other car: $_____

Were you surprised by the impact? Yes No If no, how did you brace? Hands Feet

If "Driver," was your foot on the brake? Yes No Was your foot knocked off the pedal? Yes No

If "Driver," were your hands on the steering wheel? Right hand Left hand Both hands

Were you wearing a seatbelt? Yes No Both lap/shoulder belt Lap belt Shoulder belt

Does your car have a headrest? Yes No Headrest set: Low Middle High

Does your car have airbags? Yes No Did they deploy? Yes No

What direction was your **body** facing at impact? Straight ahead Turned right Turned left

What direction was your **head** facing at impact? Straight ahead Turned right Turned left

Did any body part strike any part of the vehicle at impact? Yes No

What part of your body struck what? _____

Did you suffer any cuts? Yes No Where? _____

Did you suffer any bruises? Yes No Where? _____

Did you suffer fractures? Yes No Where? _____

Did your seat break or bend? Yes No

Immediately after the collision:

Were you knocked unconscious?	Yes	No	If yes, for how long? _____
Feel pain?	Yes	No	Where? Head Neck Upper/Middle Back Low Back
Loss of range of motion?	Yes	No	Where? Neck Upper/Middle Back Low Back
Visual disturbance?	Yes	No	
Hearing disturbance?	Yes	No	
Dizziness/Vertigo?	Yes	No	
Nausea?	Yes	No	
Vomiting?	Yes	No	
Numbness?	Yes	No	Where? _____

Please describe how you felt:

AT TIME OF IMPACT: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

Since the collision, have you experienced: (circle all that apply)

O=occasional S=sometimes P=persistent

Nausea	O	S	P
Vomiting	O	S	P
Disoriented	O	S	P
Amnesia	O	S	P
Irrability	O	S	P
Lethargy	O	S	P
Cognitive changes	O	S	P
Vision blurred	O	S	P
Altered breathing	O	S	P
Loss of consciousness	O	S	P
Headache	O	S	P
Migraine	O	S	P
Personality changes	O	S	P
Walking difficulty/ataxia	O	S	P
Deviated gaze/eye movement	O	S	P
Ringing in ears	O	S	P
Light sensitivity	O	S	P
Balance problems	O	S	P

Police and Emergency Care:

Was the collision reported to the police? Yes No Report filed? Yes No **provide copy of report*

Where did you go after the collision? Home Work Urgent Care Hospital/ER

How did you get there? _____

Were you admitted? Yes No If yes, how many days? _____

Name of hospital? _____ Attending doctor_____

What other doctor(s) have you seen for this injury? _____

What treatment did you receive? (circle all that apply)

None / X-rays / Pain medication / Muscle relaxants / Anti-Inflammatories / Stitches / Cervical collar / Labs

Physical therapy / Concussion education / Referred to MD / Referred to chiropractor / Other: _____

Prescription medications taken AFTER the collision _____

Self treatment (e.g., bed rest, ice, OTC medication, etc.)_____

CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE COLLISION

Neck pain/stiffness	Low back pain	Pain, right shoulder	Pain, right fingers
Neck muscle spasm	Sciatica, right side	Pain, left shoulder	Pain, left fingers
Numbness in shoulders	Sciatica, left side	Pain, right elbow	Pain, right hip
Numbness in arms	Numbness, right leg	Pain, left elbow	Pain, left hip
Numbness in hands	Numbness, left leg	Pain, right forearm	Pain, right knee
Midback pain	Numbness, right toes	Pain, left forearm	Pain, left knee
Numbness in midback	Numbness, left toes	Pain, right wrist	Pain, right ankle/foot
Midback muscle spasm	Sleeping problems	Pain, left wrist	Pain, left ankle/foot
Rib pain/sprain	Difficulty walking	Pain, right hand	Muscle weakness
Upset stomach	Buzz/Ringing in ears	Pain, left hand	Irritability/Nervousness
Loss of taste	Loss of smell	Loss of memory	Anxiety

Are you currently working? Yes No How many hours/week? _____

Have you missed any time from work? Yes No Dates:_____

How long have you worked at current employer? _____ Work Stress: Relaxed Moderate Stressful

At work, are you required to **(in # of hours)**?

____Lift ____Sit ____ Stand ____Walk ____Drive ____Computer/Phone ____Repetitive movements ____Other

What limitations do you experience as a result of this injury?

____Lifting ____Sitting ____ Standing ____Walking ____Driving ____Computer/Phone ____Repetitive movements

Further describe limitations: _____

Since this injury occurred, are your symptoms: Improving Getting worse Staying the same

Any daily activity restrictions as a result of this injury? Yes No Describe_____

Patient/Guardian Signature: _____ Date: _____

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PERSONAL INJURY FINANCIAL POLICY

Who Was At-Fault?

_____ I was at-fault for the collision
_____ Another person was at-fault for the collision

WE DO NOT ACCEPT THIRD-PARTY COLLISIONS WITHOUT ATTORNEY REPRESENTATION

Medical Payments:

_____ I have medical payments on my OWN auto insurance policy $_____max limits
_____ I do not have medical payments on my OWN auto insurance policy

Attorney Information:

_____ I have retained an attorney
_____ I have not retained an attorney

Attorney's Name: _____ Phone#: _____

Your Auto Insurance Information (not personal medical insurance)

Your Name:_____

Your Insurance Company:_____ Claim#:_____

Agent/Adjustor's Name: _____ Phone#:

Other Driver's Insurance Information

Other Driver's Name:_____

Other Driver's Insurance Company:_____ Claim#:_____

Agent's/Adjustor's Name: _____ Phone#:

I understand and acknowledge that if have medical payments on my own personal automobile insurance policy OR have contracted an attorney, the responsible insurance company will be billed directly. For all other third-party claims, payment is due at time of service. I authorize Intouch Chiropractic to render necessary services to me and I acknowledge that I am ultimately am responsible for all charges incurred at the time of service.

Patient/Guardian Signature: _____ Date: _____

Consent to Physical Examination and X-Rays

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

During your examination, the doctor may determine that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patient's consent for such tests.

I understand that the doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests, x-rays and physical examinations.

Patient/Guardian Signature: _____Date: _____

Females Only: Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time that I am pregnant. If determined at a later date that I am pregnant, I do not hold the doctor, health care provider's associates, association, corporation, partnership, employees, agents and estate of this establishment accountable in any way.

Last menstrual cycle:_____

Patient/Guardian Signature: _____ Date: _____

I have provided all information to the best of my ability. I accept and acknowledge ultimate responsibility for all charges incurred in this office. Payment is due at time of service.

Patient/Guardian 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 typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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/Guardian Signature: _____ Date: _____

Witness Name: _____

Patient Consent for Use & Disclosure of Protected Health Information

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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 with healthcare providers who may be involved directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

We use an 'open adjusting' area. If at any time you prefer or need a 'closed' adjusting area or would like to discuss your health in the privacy of a closed room, please communicate this to a member of our staff. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient/Guardian Signature: _____ Date: _____

Assignment

I hereby instruct and direct _____ Insurance Company to pay by check or EFT any insurance benefit payments to: Intouch Chiropractic, 2425 Camino Del Rio South #100, San Diego, CA 92108

In the event that a check(s) is/are mailed to me, or if my current policy prohibits direct payment to doctor, I understand that I am responsible for bringing the check(s) into the office <u>within 7 days</u> so that my account can be properly credited.

THIS IS A DIRECT IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this 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 any insurance company, adjuster, or attorney involved in this case. I also authorize the request of medical records, reports and imaging which are pertinent to the delivery of my care by this office. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Intouch Chiropractic provides its services directly to you, not your insurance company. I have read and understand that I am ultimately liable for my bill.

Patient Name: _____ Date: _____

_____ Witness: _____

Signature of Policyholder