

# New Patient Health History Form

**In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.**

## **Patient Data**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date \_\_\_\_\_ Email\* \_\_\_\_\_

\* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

## **Mailing address**

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

Telephone (Work) \_\_\_\_\_ (home) \_\_\_\_\_ Referred By \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Number of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Health Status \_\_\_\_\_

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

## **Current Complaints**

Nature of Injury:  Automobile\*  Work  Other

Please describe: \_\_\_\_\_

Date of Injury \_\_\_\_\_ Date symptoms appeared \_\_\_\_\_

Have you ever had same condition?  No  Yes If yes, when? \_\_\_\_\_

List of other practitioners seen for this injury/condition \_\_\_\_\_

Have you ever been under chiropractic care?  No  Yes

If yes, please describe \_\_\_\_\_

## **Insurance Information**

Name of party responsible for payment \_\_\_\_\_ Phone \_\_\_\_\_

Do you have health insurance?  No  Yes Name of company \_\_\_\_\_

\* If an auto accident, please provide:

Insurance Company Name \_\_\_\_\_ Contact Person \_\_\_\_\_

Phone: \_\_\_\_\_ Claim # \_\_\_\_\_

## **Signatures**

Name of the insured \_\_\_\_\_  
I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's or guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

### Medical History

Have you been treated for any conditions in the last year?  No  Yes

If yes, please describe

Date of last physical exam  Is there a chance that you are pregnant?  No  Yes

Have you had X-rays taken?  No  Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

### Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

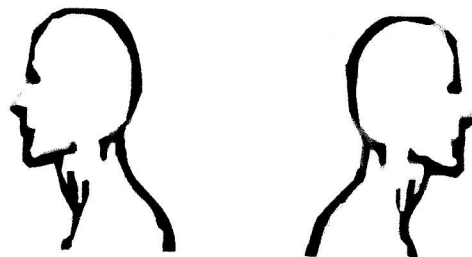
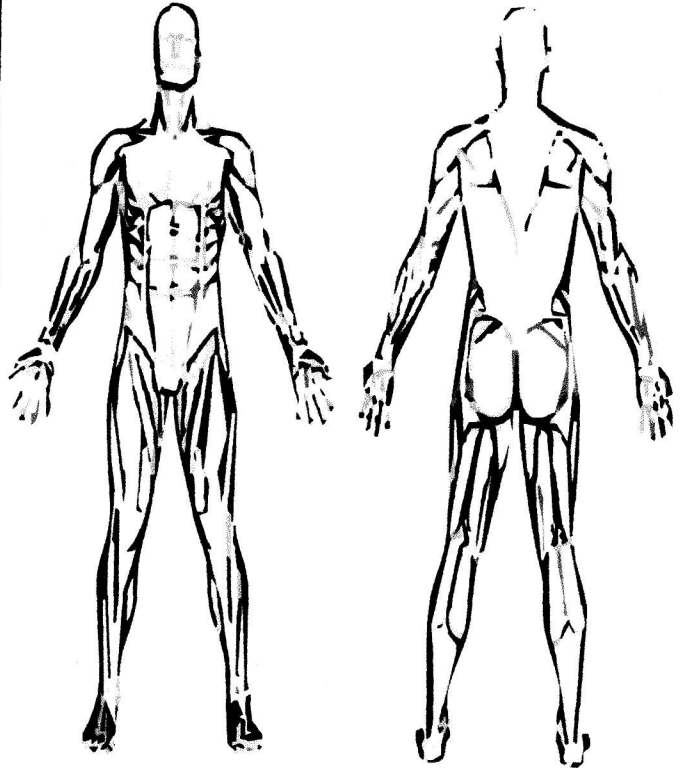
Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Have you ever suffered from:**

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache                      O=Other  
 B=Burning                P=Pins & Needles  
 N=Numbness            S=Stabbing



**HIPAA PRIVACY NOTICE THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Frank A. Lee Chiropractic is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Health Center. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the office of Frank A. Lee Chiropractic by placing the files in a box or brief case and kept within the custody of the doctor authorized to remove the files from our office.

**NO CONSENT REQUIRED**

Frank A. Lee Chiropractic may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, Frank A. Lee Chiropractic will provide your PHI to those health care professionals, whether on Frank A. Lee Chiropractic staff or not, directly involved in your care so that they may understand your health condition and needs.

(b) Payment - In order to get paid for services provided to you, Frank A. Lee Chiropractic will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

Frank A. Lee Chiropractic may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if Frank A. Lee Chiropractic obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists Frank A. Lee Chiropractic in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

**Privacy Notice**

**(d) Emergency Situations**

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that Frank A. Lee Chiropractic attempts to obtain your Consent as soon as possible; or
- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e)Communication Barriers - If, due to substantial communication barriers or inability to communicate, Frank A. Lee Chiropractic has been unable to obtain your Consent and Frank A. Lee Chiropractic determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g)Abuse, Neglect or Domestic Violence - To a government authority if Frank A. Lee Chiropractic is required by law to make such disclosure. If Frank A. Lee Chiropractic is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h)Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i)Judicial and Administrative Proceeding - For example, Frank A. Lee Chiropractic may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j)Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, Frank A. Lee Chiropractic may disclose your PHI if Frank A. Lee Chiropractic believes that your death was the result of criminal conduct.

(k)Coroner or Medical Examiner - Frank A. Lee Chiropractic may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l)Organ, Eye or Tissue Donation - If you are an organ donor, Frank A. Lee Chiropractic may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m)Research - If Frank A. Lee Chiropractic is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n)Avert a Threat to Health or Safety - Frank A. Lee Chiropractic may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o)Workers' Compensation - If you are involved in a Workers' Compensation claim, Frank A. Lee Chiropractic may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system

**You Have a Right to**

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Health Center's Privacy Officer. Frank A. Lee Chiropractic can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to Frank A. Lee Chiropractic. Frank A. Lee Chiropractic will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Health Center upon request to Frank A. Lee Chiropractic.

I acknowledge that I was provided a copy of the Notice of Privacy and that I have read them or declined the opportunity to read them and understand the Notice of Privacy. I understand that this form will be placed in my patient chart and maintained for six years.

\_\_\_\_\_  
Name of patient (name of parent if patient is a minor)

\_\_\_\_\_  
Signature of patient (signature of parent if patient is a minor)

\_\_\_\_\_  
Date

**Fee Schedule**

Core Performance chiropractic offers the following fee schedule for our patients. For our patients wishing to utilize their insurance, we will provide you with an invoice which can be sent your insurance company for reimbursement.

<b>Service</b>	<b>Fee</b>
Initial Exam	\$100
Office visit	\$65
Minors (under 18)	\$45
Smart Tools(IASTM)-15 min	\$45
RockTape Taping	\$15
Missed appointment	\$25

**Missed Appointment/Non-Cancellation Fee:** (unless a prior 24-Hour notification has been made by patient) As a courtesy, we ask that our patients provide an advance notification, if this advanced notice is not received, we will access a \$25.00 missed appointment/non-cancellation fee to your account.

Initial: \_\_\_\_\_

Payment for services must be made on the day the service(s) are provided. Initial: \_\_\_\_\_

With my signature below, I hereby acknowledge receipt of the Fee Schedule of Core Performance Chiropractic and I agree with the aforementioned policies.

\_\_\_\_\_  
Patient name (Name of parent if patient is a minor)

\_\_\_\_\_  
Patient signature (Signature of parent if patient is a minor)

\_\_\_\_\_  
Date

## **INFORMED CONSENT FOR CHIROPRACTIC CARE**

To the patient (or their parent, legal guardian, court appointed conservator, or agent): Please read this entire form prior to signing it. It is important that you understand the information contained in this form. Please ask any questions prior to signing this form if you are unclear about anything in this form.

### **Chiropractic Adjustments -**

The primary treatment rendered by the Doctor of Chiropractic to you will be chiropractic adjustments, which are purposely intentioned movements of bones with the desired effect being to remove interference to nerves, which then allows your body to use its innate ability to heal itself. Chiropractic adjustments also have the desirable effect enabling muscles, tendons, and ligaments to properly function and heal, and also allows blood flow to properly occur. Chiropractic adjustments can be made by either the use of hands or mechanical instruments to any bone or joint in the body including both spinal and extremity bones. You may or may not hear an audible sound, which is just air being released from the joint space as bones are moved into their proper positions.

### **Other Procedures -**

There are a number of other procedures used by Doctors of Chiropractic that may be used on you. A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, range of motion testing, muscle strength testing, various neurological and orthopedic testing, and other testing. Radiology is the use of x-rays on the human body and is used to gain an inside perspective of the human body that cannot be obtained from a physical examination. Treatment may include chiropractic adjustments, physical therapy (such as ultrasound, interferential therapy, massage therapy, exercise recommendations, etc.). Additionally, there may be referrals to other doctors as necessary, and their treatment should involve the same informed consent with disclosure of risks and benefits as is being done here. For example, there can be permanent pain as a side effect of surgery as one possible consequence of that procedure.

### **Potential Benefits of Chiropractic and Associated Care -**

The vast majority of chiropractic patients tend to achieve good to excellent improvement in their physical conditions with chiropractic care. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and other ways. It must be remembered that different people get different results, different people have different pre-existing conditions, and are of different ages and occupations (with different types of physical stress). *Your situation is unique, and no guarantees are given. You will have to determine what results you get for yourself and report them to your Doctor of Chiropractic.*

### **Material risks Inherent with Chiropractic Adjustments and Other Treatment -**

As with any healthcare procedure, there are certain complications which may arise when chiropractic adjustments and other care/procedures are performed. These complications include but are not limited to fractures of bones, disc injuries, dislocations, muscle strains, cervical myelopathy, strokes, radiation exposure, costovertebral strains and separations, and burns. Some patients feel some stiffness and/or soreness following the first few days of treatment. The physical exam can temporarily worsen symptoms, but is a necessary part of chiropractic care. The Doctor of Chiropractic will make every reasonable effort during the examination to screen for contraindications to care, but remember it is your responsibility to inform the Doctor of Chiropractic of any conditions that would not otherwise come to their attention.



**Probability of Risks Occurring -**

Fractures are rare occurrences and generally result from some underlying weakness of bone. Even though a competent history, examination (which may include radiography) will be performed, it is still possible for some weaknesses of bone to be undetected. Extremely rare are strokes from vertebral artery dissection which also occur in about one person in 133,000 in general (not related to chiropractic), but are estimated to occur in between one in one million and one in five million cervical adjustments. Although discs are generally helped with chiropractic care, they can be worsened even to the point of requiring surgical care (although this rarely occurs). Physical therapy can sometimes burn skin by irritating it, although this is unlikely to occur.

A perspective on the risks of chiropractic care as compared to medical care can be seen by the money paid by different doctors for a \$1,000,000 malpractice liability policy. The following annual premiums listed are close approximations, although not exact. A general medical doctor pays about \$20,000 per year, an internal medicine specialist pays about \$50,000 per year, and medical specialists such as surgeons, cardiologists, and obstetrics and gynecologists (OBGYN) pay about \$150,000 per year for a \$1,000,000 malpractice liability policy. In stark contrast to medical doctors who patients encounter significant more risk that Doctors of Chiropractic, Doctors of Chiropractic in California pay about \$3,000 per year. Also, it has been reported that about 187,000 deaths occur every year from medical malpractice, but that the number for chiropractic is typically zero per year.

**Consequences of Not Obtaining Chiropractic Care -**

Not obtaining chiropractic care will have the effect of not obtaining its benefits such as having your body function at its best ability, reducing pain, peak athletic performance, etc. Not obtaining chiropractic care may allow formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult, requiring more time (and money), and less effective when chiropractic care is obtained later in time. Not obtaining chiropractic care following trauma such as whiplash or other effects of automobile accidents will cause injured muscles, tendons, and ligaments to heal improperly and be significantly weaker and more prone to reinjury as compared to receiving proper chiropractic care.

**Alternatives to Chiropractic Care -**

Other treatment options for your condition may include rest, acupuncture, physical therapy, medical care, medications (both over the counter and prescribed), hospitalization, and surgery, and others. If you choose to use other treatment options, you should discuss the risks and benefits with your medical doctor or other provider.

**DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM. UPON DOING SO, PLEASE COMPLETE THE INFORMATION AND SIGN THIS FORM.**

\_\_\_\_\_  
Signature of Patient,  
Guardian, Conservator, or Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Printed Name