FALLBROOK SPINE CENTER, 577 E. Elder Street, Suite E, Fallbrook, CA 92028 / *ph* (760) 728-8999 / *fax* (760) 728-0821
CARLSBAD ORTHOPAEDIC GROUP, 2777 Jefferson Street, Suite 100, Carlsbad, CA 92008 / *ph* (760) 434-0033 / *fax* (760) 434-0027

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Name: First _____ Middle _____ Last _____

If patient is a minor, name of parents/legal guardian: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Ph. _____ E-Mail _____

Date of Birth: _____/_____/_____ Sex: ❑Male ❑Female SSN _____

Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced ❑Separated

Occupation _____ Employer _____ Phone _____

Employer Address _____

How did you hear about our office? _____

INSURANCE INFORMATION

Name of Insured _____ Relationship _____ Date of Birth _____

Insurance Company _____ Phone _____

Address _____

Insured's ID # _____ Group/Plan _____ Policy # _____

Person Responsible for this account (if other than patient) _____ Relationship _____

Address _____ Phone _____

AUTHORIZATION AND RELEASE

I authorize the relase of any information, including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such are to a third party payor and/or other health practioners.

I authorize and request my insurance company to pay directly to the doctor or the doctor's group, insurance benefits otherwise payable to me, regarding services performed in this clinic.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all servies rendered on my behalf or my dependents.

I certify that 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 office immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature (Parent if Minor) _____ Date _____

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HEALTH HISTORY - Page 1 of 2

Patient Name _____

Chief Complaint _____

Date Problem Began: _____/_____/_____ Is your problem: ❑Work Related? ❑Auto Related?

Describe your current problem and how it began: _____

How often are your symptoms present? ❑0-25% ❑26-50% ❑51-75% ❑76-100%

Can you perform your daily activities? ❑Yes ❑No If no, please describe: _____

Using the pain scale below, please choose the number which best describes your pain:

	No Pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain
What is your pain **RIGHT NOW?**		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
What is your **TYPICAL** or **AVERAGE** pain?		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
What is your pain **AT ITS WORST**?		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	

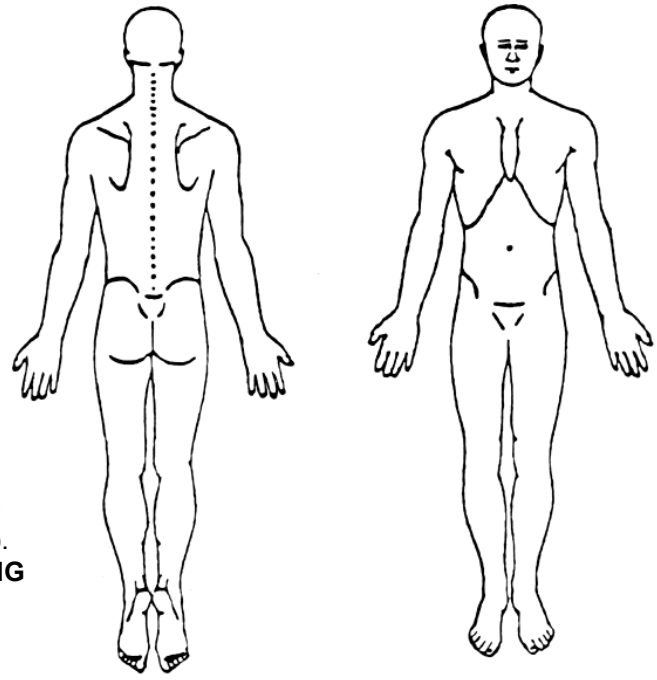
What makes it worse? _____

What is your pain **AT ITS BEST**?		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	

What makes it better? _____

Pain Scale

- 0-1 **Minimal:** The pain is an annoyance but does not stop me from working.
- 2-3 **Slight:** I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
- 5 **Moderate:** The pain causes a marked handicap in my ability to work but I can continue.
- 7-8 **Moderate To Severe:** The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
- 10 **Severe:** The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.



Using the pain scale above, mark the areas of **PAIN** on the the diagram to the right with a "**P**" and the pain level (example **P-4**). Also, mark the areas of **NUMBNESS** with an "**N**" and **TINGLING** with a "**T**."

List any other symptoms or health concerns you have: _____

Are you involved in sports or regular exercise? If yes, please describe including frequency: _____

Do you have any hobbies? If yes, please describe: _____

Have you had X-rays, MRI, CT Scan? ❑Yes ❑No If yes, what areas, when and where: _____

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HEALTH HISTORY - Page 2 of 2

Patient Name _____

List ALL surgeries (including cosmetic) you have undergone, and when: _____

_____

Other Injuries/Hospitalizations/Surgeries/Illnesses (please check all of the following that apply to you):

	Date		Date
❑History of Recent Infection	_____	❑Recent Fever	_____
❑HIV/AIDS	_____	❑Diabetes	_____
❑High Blood Pressure	_____	❑Stroke	_____
❑Numbness in Groin/Buttocks	_____	❑Arthritis	_____
❑Urinary Retention	_____	❑Dizziness/Fainting	_____
❑Aortic Aneurysm	_____	❑Cancer/Tumor	_____
❑Frequent Urination	_____	❑Prostate Problems	_____
❑Pregnancy, # of births _____	_____	❑Osteoporosis	_____
❑Abnormal Weight Gain / Loss	_____	❑History of Neck/Back Pain	_____
❑Visual Disturbances	_____	❑Recent Trauma	_____
❑Epilepsy/Seizures	_____	❑Hepatitis	_____
❑Alcohol/Drug Addiction	_____	❑Hernia	_____
❑Thyroid Problems	_____	❑Ulcer	_____
❑Constipation	_____	❑Easily Bruised	_____
❑Emotional Disorders	_____	❑Tuberculosis	_____
❑Rheumatic Fever	_____	❑Migraine Headaches	_____
❑Asthma	_____	❑Kidney Disease	_____
❑Hemorroids	_____	❑Gallstones	_____
❑Insomnia	_____	❑Shingles	_____
❑Syphillis	_____	❑Chlamydia	_____
❑Herpes __Genital __Oral	_____	❑Gonorrhea	_____

❑Allergies (including medications) _____

Are you currently seeking treatment with other professionals for any condition marked above? ❑Yes ❑No

If yes, for what and with whom? _____

When was your last physical examination? _____

Please list ALL prescription medications you are currently taking and what you are taking them for _____

_____

Please indicate the use and frequency of the following:

	How Much per Day		How Much Per Day		How Much Per Day
❑Coffee/Black Tea	_____	❑Water	_____	❑Alcohol	_____
❑Recreational Drugs	_____	❑Soda Pop	_____	❑Tobacco	_____
❑Non-Prescription Medication and what you are taking it for _____					_____
_____					_____
_____					_____

Family History: ❑Cancer _____ ❑Diabetes ❑High Blood Pressure ❑Cardiovasular Problems ❑Stroke

What type of treatment(s) are you interested in receiving? ❑Medical/Orthopedic ❑Chiropractic ❑Nutrition Therapy ❑Massage Therapy ❑Physical Therapy ❑Unsure

What are your goals regarding treatment?

❑Pain Management ❑Functional Restoration ❑Overall Wellness ❑Other _____

I certify that the information on this questionnaire is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this clinic of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Signature (Parent if Minor) _____ *Date* _____

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NOTICE OF PRIVACY PRACTICES - 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! We are required by law to maintain the privacy and confidentiality of your protected health information and to provide patients with notice of our legal duties and privacy practices with respect to your protected health information. This notice is effective as of October 1, 2004. This clinic 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 questions about any part of this notice or if you want more information, you may contact the office manager of this clinic or make an appointment with the appropriate staff of this clinic for a personal conference in person or by telephone within two working days. The clinic 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, this clinic is required by law to comply with this notice.

DISCLOSURE OF YOUR HEALTHCARE 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. For example, on occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with our clinic. It is our policy to provide a substitute healthcare provider, authorized by our clinic to provide assessment and/or treatment to our patients without advanced notice, in the event of our absence due to vacation, sickness or other emergency situation.

Payment - We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations. For example, as a courtesy, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this facility for healthcare services rendered. If you pay for your healthcare services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the healthcare services received.

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 or of your death.

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 Procedures - We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement - We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons - We may disclose your health information to coroners or medical examiners.

Organ Donation - We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research - We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety - It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies - We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing - We may contact you for marketing purposes or fundraising purposes. For example, as a courtesy, we may call you the day prior to an appointment to remind you of the appointment. If you are not available to take the call, we may leave a reminder message. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to change your appointment. Also, we may contact you by way of mail inviting you to participate in a charitable activity we are sponsoring or special event we are hosting. We will provide you with information about the activity or event. We will not disclose any personal health information about your condition for the purpose of such activities or events.

Change of Ownership - In the event that this clinic 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, however, that this clinic is not required to agree to the restriction that you request. 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 the right to request that this clinic amend your protected health information. Please be advised, however, that this clinic 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 the right to receive an accounting of disclosures of your protected health information made by this clinic. You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

COMPLAINTS

Complaints about your privacy right or how this clinic has handled your health information should be directed to the office manager of this clinic or you may make an appointment for a personal conference in person or by telephone within two 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, D.C., 20201.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide this clinic to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in this Privacy Notice.

_____ _____

Patient's Name (Please Print) *Parent or Legal Guardian, if Patient is a Minor (Please Print)*

_____ _____

Patient's Signature (Parent/Guardian, if Minor) *Date*

_____ _____ _____

Authorized Staff Member (Please Print) *Signature* *Date*

INFORMED CONSENT

The Nature and Risks of Chiropractic Treatment: Chiropractic, by far, is the safest choice of health care, including dentistry, acupuncture and dermatology. However, since there is a remote chance of complications or iatrogenic mishap, we feel it is the responsibility of this facility to inform you prior to rendering care. The primary treatment used by the doctors of this facility is the spinal/extremity manipulation. We will likely use that procedure to treat you. The doctors will use their hands upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel or sense movement. This is a normal, healthy reaction.

Some patients will feel some stiffness and soreness following the first few days of treatment. This is a normal, healthy reaction. As with any healthcare procedure, there are certain complications which may arise during a joint manipulation. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations. 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. The most serious and most publicized by opponents of chiropractic care is vascular injury, specifically if it leads to stroke.

The Probability of Those Risks Occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such outcome. (1) Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare" (muscle or joint injury, fracture and neuropathy).

Ancillary Treatment: In addition to manipulation, the following treatments and diagnostic procedures may be used: ultrasound, ice packs, hot packs, muscle stimulation, galvanic current, traction, physical therapy, massage, x-ray and orthopedic/neurologic testing. Of these ancillary procedures, ultrasound carries the most significant risk. Ultrasound has the potential, which is rare, to cause periosteal burns (irritation of the outer layer of bone).

The Availability and Nature of Other Treatment Options: Other treatment options for your condition include: self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain killers; hospitalization with traction; surgery.

The Material Risks Inherent in Such Options and the Probability of Such Risks Occurring Include: Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks, some with rather high probabilities.

Hospitalization in conjunction with other care, bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure, dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks varies according to many factors.

The Risks and Dangers Attendant to Remaining Untreated: Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN BELOW UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended and waive all doctors and staff of the responsibility for said risks. I understand that, while chiropractic care can be effective in alleviating, reducing or resolving neuromusculoskeletal complaints, there are no guarantees for such results. Having been informed of the risks, I hereby give my consent for the doctors and staff of this facility to render treatment deemed necessary for my condition.

_____ _____

Patient's Name (Please Print) *Parent or Legal Guardian, if Patient is a Minor (Please Print)*

_____ _____

Patient's Signature (Parent/Guardian, if Minor) *Date*

_____ _____ _____

Authorized Staff Member (Please Print) *Signature* *Date*