IRVINE CHIROPRACTIC CENTER

~ Patient Information ~

Name:_____
First Middle Last

Mailing Address:_____City:_____State:_____Zip:_____

Email Address:_____

Phone #: (H)_____ (W)_____ (C)_____

Date of Birth:_____ Age:_____ Sex: ☐ Male ☐Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Minor

Occupation:_____ Employer:_____

How did you hear about our Wellness Center?_____

Emergency Contact/Relation:_____ Phone #: (H)_____ (C)_____

~ Accident Information ~

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐Other_____

Has it been reported? ☐ Yes ☐ No If yes, to whom? _____

~ Insurance Information ~

Do you have health insurance? ☐ Yes ☐ No Name of Carrier:_____

Policy Holder Name:_____ Date of Birth:_____

Relationship to Patient (if other than self):_____ Phone # of Insured:_____

Please provide this office with a copy of your insurance card.

~ Benefits Assignment ~

(Insured Patients Only)

I certify that my (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE PAYMENTS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including diagnosis and records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, excluding electronic submissions.

Signature:_____ Date:_____

Health History

Please check to indicate if you are *currently experiencing* any of the following:

☐ Neck Pain/Stiffness	☐ Difficulty walking	☐ Rashes	☐ Ringing in ears
☐ Back Pain/Stiffness	☐ Joint pain	☐ Fatigue	☐ Loss of taste/smell
☐ Arm/Hand Pain	☐ Cold hands or feet	☐ Racing heart	☐ Shortness of breath
☐ Leg/Knee Pain	☐ Headaches	☐ Chest pain	☐ Stomach problems
☐ Numbness/tingling in arms/hands	☐ Blurred vision	☐ Bloating	☐ Constipation
☐ Numbness/tingling in legs/feet	☐ Mood swings	☐ Heart burn	☐ Bowel/bladder changes
☐ Pins/Needles in arms	☐ Dizziness	☐ Night sweats	☐ Sleeping difficulties
☐ Pins/Needles in legs	☐ Memory loss	☐ Nervousness	☐ Sudden weight loss
☐ Swelling in hands or feet	☐ Fainting	☐ Cough	☐ Loss of appetite
☐ Allergies	☐ Sleeping difficulties	☐ Wheezing	☐ Jaw pain/tightness

Please check to indicate *if you have ever had* any of the following:

☐ Arthritis	☐ Scoliosis	☐ Pinched nerve	☐ Herniated Disc
☐ Fibromyalgia	☐ Osteoporosis	☐ TMJ	☐ Ulcer
☐ Sprains, Strains	☐ Migraines	☐ Orthopedic Surgery	☐ Rheumatoid arthritis
☐ Diabetes	☐ Neuropathy	☐ Bone fractures	☐ High Cholesterol
☐ Heart Disease	☐ Stroke	☐ Heart arrhythmia	☐ Thyroid Problems
☐ Depression	☐ Anxiety	☐ Heart murmur	☐ Cancer
☐ Concussion	☐ Liver Disease	☐ Kidney Disease	☐ Bleeding Disorders
☐ Car accidents	☐ Serious falls	☐ Asthma	☐ High blood pressure

Are you currently under medical care? ☐ Yes ☐ No Date of last physical exam: _____
Primary Care Physician name: _____

- Allergies to: Medications_____ Food _____
- Current Medications_____
- Supplements: _____

Does you work involve mostly: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor
Do you exercise: ☐ Never ☐ Daily ☐ ___ days/week Exercising now? ☐ Yes ☐ No
Daily Intake: Caffeine ___ cups/day Alcohol ___ drinks/week Cigarettes ___ packs/day

Additional Health Concerns:

☐ Weight Gain	☐ Low energy	☐ Fatigue	☐ Daytime sleepiness
☐ Hormonal Changes	☐ Poor sleep	☐ Mood swings	☐ Decreased motivation
☐ Stress	☐ Nutrition	☐ Exercise	☐ Difficulty concentrating
☐ Seasonal Allergies	☐ Weight loss	☐ Food allergies	☐ Environmental Allergies

Anything else you that is important for us to know about you or your health care needs?

_____

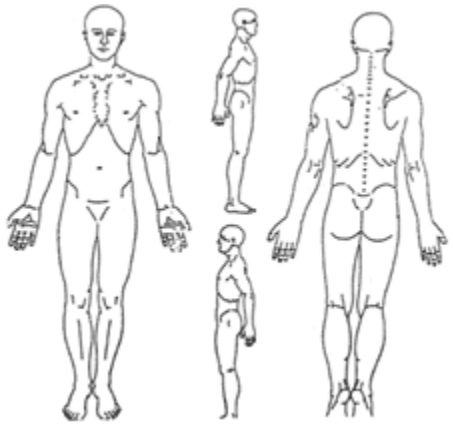
_____

Patient Signature: _____ Date: _____
Reviewed by Provider: _____ (Initials)

~ Current Health Condition ~

Purpose of today's appointment:_____

Please indicate on the diagrams below your areas of pain or discomfort:



How long have you been experiencing your primary complaint? _____

Is your pain: ☐Dull ☐Achy ☐Sharp ☐Numb ☐Tingling ☐Burning ☐Throbbing

Does your pain radiate down your arms and/or legs? ☐Yes ☐No If yes, please describe:_____

_____

Do you know what caused your current condition? ☐Yes ☐No If yes, please describe:_____

_____

Is the pain: ☐Constant ☐Frequent ☐Intermittent ☐Occasional

What makes the pain feel better?_____

What makes the pain feel worse?_____

Use the scale below to rate the pain of your primary complaint:

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

~ Neurological/MRI/Vascular Patient Questionnaire ~

NAME:_____ DATE:_____

For any Yes answer, please include details:

1. Do you suffer from neck pain with pain in your shoulders, arms or hands? NO ☐ YES ☐
   Comments:_____
2. Do you have weakness, numbness or burning in your shoulders, arms or hands? NO ☐ YES ☐
   Comments:_____
3. Do your hands or arms fall asleep regularly? NO ☐ YES ☐
   Comments:_____
4. Do you have reduced feeling (sensations) or swelling in your hands or arms? NO ☐ YES ☐
   Comments:_____
5. Do you suffer from a loss of handgrip strength? NO ☐ YES ☐
   Comments:_____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO ☐ YES ☐
   Comments:_____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO ☐ YES ☐
   Comments:_____
8. Do your legs or feet fall asleep regularly? NO ☐ YES ☐
   Comments:_____
9. Do you have reduced feeling (sensation) or swelling in your legs or feet? NO ☐ YES ☐
   Comments:_____
10. Do you suffer from cold hands or feet? NO ☐ YES ☐
    Comments:_____
11. Do you have frequent falls or find that you trip over your feet while walking? NO ☐ YES ☐
    Comments:_____
12. Do you suffer from headaches? If yes, how often, how severe, and what has been tried? NO ☐ YES ☐
    Comments:_____
13. Have you tried taking any medications such as an anti-inflammatory? If yes, what kind? NO ☐ YES ☐
    Comments:_____
14. Have you tried Physical Therapy or Chiropractic treatments before? If yes, When? How long? What kind? NO ☐ YES ☐
    Comments:_____
15. Have you had an MRI? If yes, when? Who ordered it? What was it ordered for? NO ☐ YES ☐
    Comments:_____
16. Have you used any splint, braces or other prescribed treatment by an MD? NO ☐ YES ☐
    If yes, When? What kind? Who ordered it?
    Comments:_____
17. If you have tried any treatment or medications, did this make your problem better? NO ☐ YES ☐
    Comments:_____

~ Informed Consent to Care ~

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, the underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Patients Signature Date

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at 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 spine health. These procedures will assist us in determining if chiropractic care is needed or if any further examinations or studies are needed. 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 prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of _____ and will expire 7 years after the date on which you last received services from us.
Date

Patients Initials:_____

Witness:_____ Date:_____

~ X-Ray Questionnaire ~

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

Name:_____

- ☐ There is a possibility I may be pregnant at this time.
- ☐ Yes, I am definitely pregnant.
- ☐ No, I am definitely not pregnant at this time.
- ☐ I request that x-ray films not be taken

  because:_____

  _____

  _____

Date of last menstrual period:_____

_____ _____

Patients Signature Date

IRVINE CHIROPRACTIC CENTER

~ Notice of Privacy Practices ~

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. The law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, your file may be reviewed by a specialist doctor whom we may involve your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your health insurance company. We may disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call you and remind you about an appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fill your request. You have the right to know of any uses or disclosures we make with your health information beyond normal uses. As we need to contact your from time to time, we will use whatever address or phone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding information you want to see. If you also want a copy of your records, we may charge a reasonable fee for the copy.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to use in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we still will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change the details of this notice, we will notify you of the changes in writing. Questions or complaints about the Notice of Privacy Practices, or how this practice handles your health information, should be directed to our Office Manager.

This notice goes into effect as of May 3, 2024.

~ Acknowledgment ~

I acknowledge that I have reviewed the Notice of Privacy Practices of Irvine Chiropractic Center.

_____	_____	_____
Signature	Print Name	Date