PATIENT HISTORY

Date:___________________

Name:____ Age:________ Date of birth:_________________

HISTORY OF PRESENT ILLNESS

Chief complaint:____ Date symptoms began:________________

Describe the pain/symptoms:____

Is this due to: Auto____ Work____ Other____

Have you ever had the same or similar condition? Yes No *If yes, when and describe*:_________________________

____

**Have you experienced any urinary or bowel changes?___________

Days lost from work:______________________ Date of last physical examination:__________________

PAST MEDICAL HISTORY

if you run out of space for any section, please continue on the bottom of the 2nd page

Have you ever been diagnosed as having or have suffered from…..? (please check all that apply)

__fractures or dislocations
__circulatory problems
__rheumatoid arthritis
__seizures/convulsions
__any congenital disease
__excessive bleeding
__respiratory problems
__osteoarthritis
__epilepsy
__pace maker
__strokes
__cancer
__depression
__ulcers
__rheumatoid arthritis
__alcoholism
__drug addiction
__HIV/AIDS
__heart disease
__high/low blood pressure
__diabetes mellitus

If checked, please explain:____

____
____
____

Have you had any other major illnesses, injuries, car accidents, or hospitalizations? *(Women, please include childbirth)*	When?

When was the last time that you were treated by a chiropractor?_________Please explain your condition and the treatment:______

____
____

What medications or drugs are you taking? (include birth control)____

____

Please list any other health problems or imbalances that you have, no matter how minor: (e.g headaches, sleep, stomach aches, etc.)

____

____

SOCIAL HISTORY

Do you drink alcoholic beverages?_______ *If so, how much per week?*__________________________

Do you use any tobacco products?_______ *If so, how much per day?*___________________________

Do you take vitamin supplements?_______*If so, please list:*____

Do you consume caffeine?________ *If so, how much per day?*_________________________________

Do you exercise?________ *If so, what is the frequency and type of exercise?*______________________________

Any other physical activities?____

What percentage of the time during an average day do you spend: lifting_____________% sitting__________________%
bending____________% at a computer______________%

FAMILY HISTORY

Father: ____living → Current age:_____________
____deceased → Age at death:_____________ Cause of death:_________________________________

Mother: ____living → Current age:_____________
____deceased → Age at death:_____________ Cause of death:_________________________________

** Check if you are adopted and know little about your birth parents/family:_________

Do you have children? yes no *If yes, name and ages*:____

____

Do you have any family members who suffer from the same condition as you?_______ If so, please list:________________________

____

FAMILY DISEASES (indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

___Tuberculosis	___Cancer	___Mental Illness
___Diabetes	___Asthma	___Heart disease
___Stroke	___Kidney disease	___Lung Disease
___Arthritis	___Liver disease	___Other: ________________________

Since omission or false information can lead to improper treatment and possible injury, the patient certifies that all of the information above is complete and true, and the chiropractor will be informed of any future changes to the patient's health status before treatment continues.

Patient's signature:____ Date:____________

**If a minor, Parent/Legal Guardian's Name ____

Signature ____ Date_____________

Doctor's signature:____ Date:____________

PATIENT INFORMATION

Date ________________

Name ____ Social Security # (Optional) ______________________

Address ____ Home Phone ______________________

City _____________________ State _______ Zip Code _______________ Cell Phone _______________________

Occupation _____________________ Employer _____________________ Work Phone ______________________

Birthdate _________________ Age ______ **M**arried / **S**ingle / **O**ther ____ Spouse's Name ____________________
(circle one)

Whom may we thank for referring you to us? ____

Health Insurance? Yes / No Company? _________________________________ Group # ___________________
(circle one)

Main Complaint ____

For In-Office Promotions Only:

Email (Optional) ____

PATIENT INFORMATION

Date ________________

Name ____ Social Security # (Optional) ______________________

Address ____ Home Phone ______________________

City _____________________ State _______ Zip Code _______________ Cell Phone _______________________

Occupation _____________________ Employer _____________________ Work Phone ______________________

Birthdate _________________ Age ______ **M**arried / **S**ingle / **O**ther ____ Spouse's Name ____________________
(circle one)

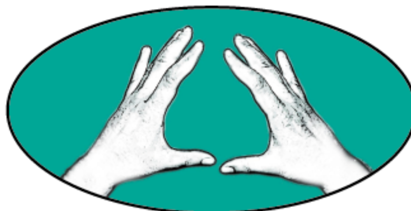
Whom may we thank for referring you to us? ____

Health Insurance? Yes / No Company? _________________________________ Group # ___________________
(circle one)

Main Complaint ____

For In-Office Promotions Only:

Email (Optional) ____



303 South Crescent Heights Boulevard
Los Angeles, California 90048
Tel: (323) 782-3900 / Fax: (323) 782-3936

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including but not limited to the various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future will treat me while employed by, working or associated with or serving as back-up for or in consultation with the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office, hospital, clinic or location.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels, at that time and based upon the facts known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name ____
(Print Name)

Patient's Signature______________________________________ Date _____________

If a minor, Parent/Legal Guardian's Name ____

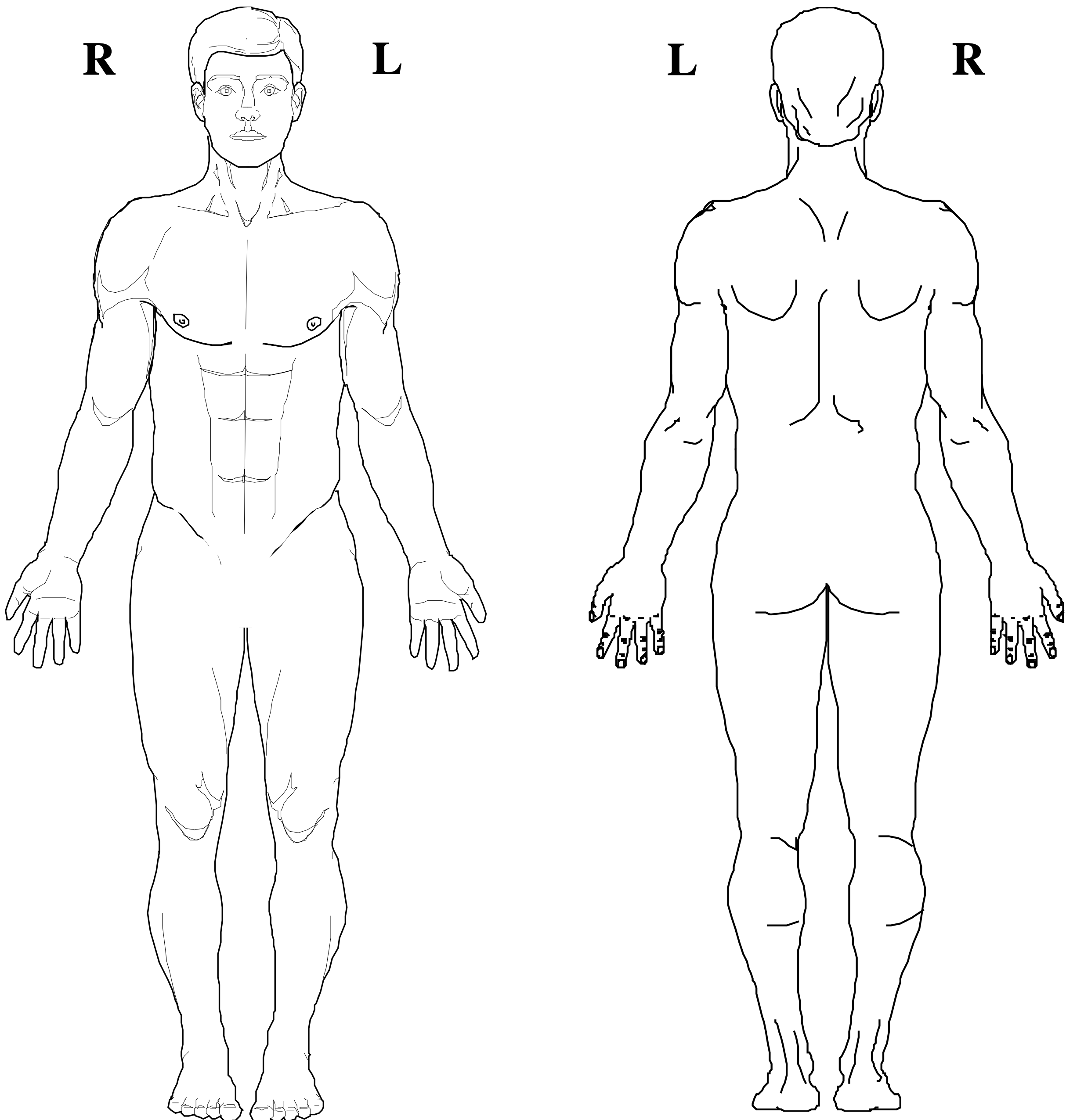
Signature______________________________________ Date_____________

Patient Area of Pain

Name: ____ Date: _____________

Please indicate the areas of discomfort using the symbols listed below. Rate each area of **Pain** on a scale from 1-10, with 10 as the most pain you could ever experience (example: **P[10]**).

P = Pain **(1-10)**
A = Ache
B = Burning
N = Numbness
T = Tingling
C = Cramping
W = Weakness



HIPAA Notice of Privacy Practices

Healing Hands
WELLNESS CENTER
303 South Crescent Heights Boulevard
Los Angeles, California 90048
Telephone (323) 782-3936

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may also be provide to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may required that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your protected health information, as necessary, to contact you in order to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

(over)

2. Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of , or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of you protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

____

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

Patient Name:____

Signature: ____ Date:____________

** If a minor, Parent/Legal Guardian's Name _________________________

Signature____ Date___________