Patient Intake

Today's Date: _____

NECK PAIN
BACK PAIN
CAR CRASH INJURY

PAIN RELIEF
CHIROPRACTOR

Your Personal Information

Patient Last Name:_____ First:_____ MI:_____
Home Address:_____ City:_____ State:_____ Zip:_____
Phone Number:_____ Alternate Number:_____
Patient Date of Birth:_____ Age:_____ E-Mail:_____
Your Occupation:_____ Your Spouse/Guardian:_____
Your Primary Doctor:_____ Primary Doctor City:_____

Patient Gender:
○ Male ○ Female

Patient Status:
○ Single ○ Married ○ Partnered ○ Widowed

Today's Visit

Are you here because you were involved in an auto collision?	○ Yes	○ No
Are you here because you were injured at work?	○ Yes	○ No
Are you here because you were injured on someone else's property?	○ Yes	○ No
Does your pain cause weakness in your hands or feet?	○ Yes	○ No

What is the reason for your visit?

Is your pain/symptom getting worse? ○ Yes ○ No

Your Pain/Symptom(s)

What does your pain feel like?
○ Wide Spread ○ Achy ○ Sharp ○ Burning ○ Numb ○ Pins/Needles ○ Throbbing ○ Stiff

Are normal activities affected? If so, please indicate:
○ Laying ○ Sleeping ○ Sitting ○ Bending ○ Standing ○ Walking ○ Running ○ Lifting

How often do you experience the symptoms?
○ Constant Daily ○ On/Off Daily ○ Few Times/Week ○ Few Times/Month

As of now, give us the severity of your pain:

0 no symptoms

2 slight discomfort

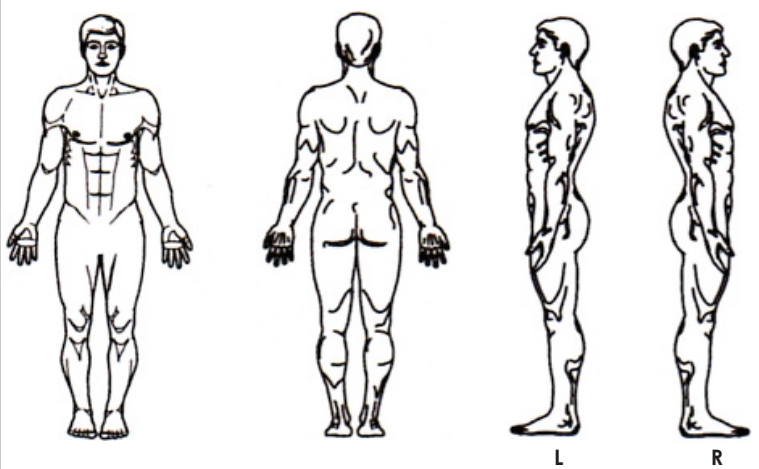
4 slightly affects personal activities

6 limits my work schedule

8 prevents all activities

10 causes thoughts of suicide

Mark your area(s) of complaint:



If your pain travels, please let us know

Your Health History:

Do you have any of these conditions?

○ Diabetes ○ Heart Disease ○ High Blood Pressure ○ Arthritis ○ Cancer
○ Others:_____
anything you would like the doctor to know

Are you taking medication? Please list all:

○ Insulin ○ Blood Thinners ○ Pain Controllers ○ Muscle Relaxers ○ Birth Control
○ Depression Meds. ○ Others:_____

Any surgeries?	○ Yes	○ No	What kind:_____
Any allergies?	○ Yes	○ No	What kind:_____
Do you smoke?	○ Yes	○ No	How much:_____
Do you drink?	○ Yes	○ No	How much:_____
Do you exercise?	○ Yes	○ No	How much:_____

Let's Review Some Systems of the Body:

Constitutional: O Fever O Chills O Fatigue O Weight Loss O Appetite Loss O Poor Sleep O Night Sweats

Musculoskeletal: O Joint Pain O Muscle/Ligament Tear O Spinal Infection O Osteoporosis O Bone Tumors O Nerve Pain

Neurological: O Sudden Headaches O **Loss of Bladder/Bowel Control** O Loss of Balance O Loss of Sensation O Slurred Speech O Sudden Numbness O Sudden Confusion O Epilepsy

Cardiovascular: O Heart Disease O High Blood Pressure O Bleeding Disorder O Irregular Heartbeat O Leg Swelling

Respiratory: O Asthma O COPD O Emphysema O Pneumonia O Lung Caner O Common Cold O Wheezing

Eyes: O Double Vision O Macular Degeneration O Glaucoma O Cataracts O Droopy Eyelid O Discharge

E|N|T: O Hearing Loss O Ringing in Ear O Vertigo O Nose Bleed O Nasal/Sinus Congestion O Sore Throat

Genitourinary: O Urine Urgency O Pain During Urination O Blood in Urine O *Can't Hold Urine/Leakage* O Prostate

Gastrointestinal: O Heartburn O Blood in Stool O Nausea/Vomiting O Abdominal Pain O Bowel Leakage/Loss

Functional: O Anxiety O Feeling Down at Times O Can't Sleep O Constantly Worried

Women Only:

To the best of your knowledge, could you be pregnant? ○ Yes ○ No

If so, what trimester are you in? ○ 1st ○ 2nd ○ 3rd

Is there anything you would like the doctor to know:_____

Acknowledgement of Receipt of Privacy Practice:

I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Pain Relief Chiropractor and the Practice's policies and procedures regarding the use and disclosure of any of my protected Health Information created, received or maintained by Pain Relief Chiropractor. In addition, I authorize Pain Relief Chiropractor to communicate protected health information through the use of mail, phone, voice mail, and personal communication. This may include electronic communication such as announcements or appointment reminders via text message.

INITIAL HERE

Informed Consent to Render Treatment:

I acknowledge that I have received, reviewed, understand and agree to Pain Relief Chiropractor new patient procedure and consent and authorize Pain Relief Chiropractor to perform evaluation and management procedures for the purpose of identifying a differential diagnosis, formulating and performing an examination, and delivering treatment. I understand Chiropractic Joint Manipulation and the associated risks, the patient examination process includes important tests that require movement, exertion, balance control and may result in worsening of symptoms, muscle strain, and falling. I accept these risks and agree that I will provide correct answers and information and I will notify Pain Relief Chiropractor if there has been a change in any of my answers and information.

INITIAL HERE

Assignment of Benefits & Release of Health Information:

I authorize Pain Relief Chiropractor to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, replying to requests from my insurance company, evaluating the quality of services provided, communicating with my referring physician, and any other administrative operations related to treatment or payment as noted in Pain Relief Chiropractor Notice of Privacy Practices. I understand that benefits quoted from my insurance carrier to Pain Relief Chiropractor are only an estimate and not a guarantee of payment. I assign Pain Relief Chiropractor all benefits payable to me under my insurance policies and health benefit plans. I shall be personally responsible for any unpaid balance.

INITIAL HERE

PRINT: _____ **SIGN:** _____

Notice of Privacy Practice

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To That Information. **Please Review This Notice Carefully.**

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is obligated to notify you promptly if a breach occurs that may have compromised the privacy and security of your PHI. The Practice is also required by law to abide by the terms of this Notice.

How The Practice May Use And Disclose Your Protected Health Information

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

Other Use & Disclosures That Are Required Or Permitted By Law

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief –We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfac-

tory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI 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.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military

command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

Authorization

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

Your Rights

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket, and we will abide by that request unless we are legally obligated to do otherwise.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must provide your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both, and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.
To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms, please sign the "Acknowledgement of Receipt of Privacy Practice" section on the Patient Intake Form.

PAIN RELIEF
CHIROPRACTOR

Informed Consent to Render Treatment

Please read this entire document prior to signing Intake Form. It is important that you understand the information contained in this document. **Please ask questions before you sign if there is anything that is unclear**

The Nature of the Chiropractic Joint Manipulation
The primary treatment I use as a Doctor of Chiropractic is Joint Manipulative Therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument 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 a sense of movement.

Analysis | Examination | Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Vital Signs, Range of Motion Testing, Orthopedic Testing, Neurological Testing, Radiographic Imaging Studies, Spinal and/or Extraspinal Joint Manipulation.

Physiotherapy Modalities, including but not limited to: Ultrasound, Electrical Stimulation, Intersegmental Mechanical Traction, Heat/Cold Therapy, Instrument Assisted Soft Tissue Mobilization, and the application of Myofascial Taping.

The Material Risks Inherent in Chiropractic Joint Manipulation
As with any healthcare procedure, there are certain complications which may arise during Chiropractic Joint Manipulation and Physiotherapy Modalities. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history, screen for during the examination and Radiographic Imaging. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options
Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated
Remaining untreated may allow the 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 to recover and less effective of an approach.

PAIN RELIEF
CHIROPRACTOR

Release of Health Information

Please read this entire document prior to signing Intake Form. It is important that you understand the information contained in this document. **Please ask questions before you sign if there is anything that is unclear**

Authorization for Use/Disclosure of Information:
I am the patient, or legally authorized representative of the patient, recognize voluntarily authorization and direct my health care provider, Sutter Spine & Sports Clinic, to use or disclose my health information during the term of this authorization to the recipients listed below, as it may be needed:

- o Consultation or Transfer of Your Care to Another Healthcare Provider
- o Your Insurance Company/Carrier
- o Attorney
- o Office of Workers' Compensation
- o Centers for Medicaid & Medicare Services

These recorders may include, but are not limited to: History & Examination, Clinical Notes, Laboratory Reports, Radiographic Studies & Reports, and Billing Information.

I understand that once my healthcare provider, Sutter Spine & Sports Clinic, discloses my information to the Recipient, the privacy and redisclosure to a third party is no longer guaranteed.

I understand that I may refuse to sign and revoke, at anytime, this authorization; and will not affect the continuation, quality, and dedicated commitment of Sutter Spine & Sports Clinic.

This Authorization does not extend to HIV testing or results, psychotherapy notes, or drug or alcohol treatment records that are protected by federal law.