New Practice Member Forms

INTERO CHIROPRACTIC

Name_____ Date _____ Age _____ ☐ Male ☐ Female

Address_____City_____State_____Zip_____

Phone: Home_____ Cell_____Cell Phone Provider_____

E-mail_____ SSN_____Birthday_____

Occupation_____ Employer's Name_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name_____

# of Children_____ Names, Ages_____

In Case of Emergency_____ Phone #_____

Who may we thank for referring you? _____

Check All Current Problems You Have

☐ Dizziness	☐ Throat Issues	☐ Kidney Problems	☐ Liver Disease	☐ Disc Problem
☐ Headaches	☐ Asthma	☐ Mid Back Pain	☐ Shoulder Pain	☐ Infertility
☐ Vertigo	☐ Ulcers	☐ Irritable Bowl	☐ Chronic Fatigue	☐ Gastric Reflux
☐ Ear Infections	☐ Numbness in Arms	☐ Sciatica	☐ Lupus	☐ Other
☐ Nausea	☐ Numbness in Hands	☐ Numbness in Legs	☐ Fibromyalgia	_____
☐ TMJ	☐ Menstrual Disorder	☐ Numbness in Feet	☐ Chest Pain	_____
☐ Neck Pain	☐ Heart Disorders	☐ Low Back Pain	☐ Arm Pain	_____
☐ Migraines	☐ Stomach Disorders	☐ Hip Pain	☐ ADD/ADHD	_____
☐ Anxiety	☐ Bladder Problems	☐ Leg Pains	☐ Nervousness	_____
☐ Chronic Sinus	☐ Thyroid Problems	☐ Knee Pain	☐ Epilepsy	_____

Have you ever seen other doctors for these conditions? ☐ Yes ☐ No

If Yes: ☐ Chiropractor ☐Medical Doctor ☐ Other_____

Who & When? _____

Name of Primary Care Physician _____

Check Any Condition You Have Now/Have Had:

☐ Stroke	☐ Cancer	☐ Heart Disease	☐ Spinal Surgery
☐ Scolosis	☐ Diabetes	☐ Spinal Bone Fracture	☐ Seizures

List all surgical operations & years_____

_____

List all over-the-counter & prescription medications you are on, and the reason for each_____

_____

Were you ever in an auto accident? If so, when?_____

Have you ever been knocked unconscious? ☐ Yes ☐ No

If so, please describe_____

Other trauma _____

History of Health Concerns

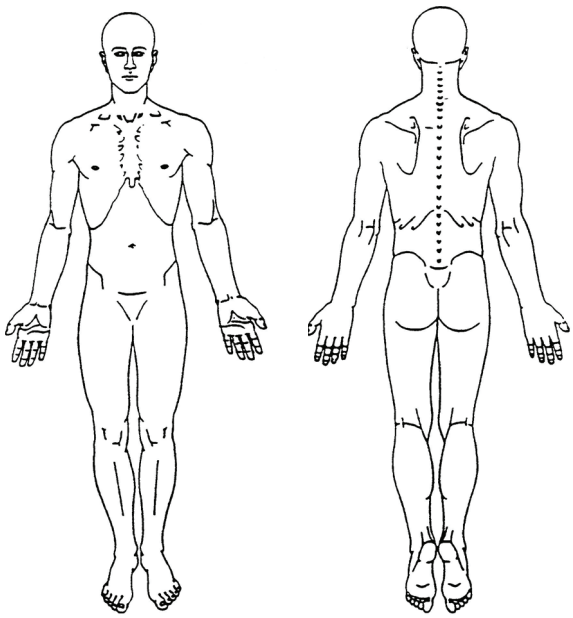
Please start at the top of your body and work your way down.

Symptom 1: _____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptom?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
  0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? _____
- Did it begin: ☐ Suddenly ☐ Gradually
- Describe how it began _____
  _____
- Have you had the symptom in the past before? ☐ Yes ☐ No
- If yes, when was the first time you've ever felt the symptom:
  _____
- What makes the symptom worse?
  _____
- What makes the symptom better?
  _____
- Does the pain radiate? ☐ Yes ☐ No
- If yes, describe in detail where it radiates _____
- Does the pain feel worse at a particular time of day?
  ☐ Morning ☐ Afternoon ☐ Early evening ☐ Late at night
  ☐ Unchanged by time of day

Please mark on the diagram with the following letters to describe your symptoms:

R=Radiating **B**=Burning **D**=Dull **A**=Aching
S=Sharp/Stabbing **T**=Tingling **N**=Numbness



Symptom 2: _____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptom?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
  0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? _____
- Did it begin: ☐ Suddenly ☐ Gradually
- Describe how it began _____
  _____
- Have you had the symptom in the past before? ☐ Yes ☐ No
- If yes, when was the first time you've ever felt the symptom:
  _____
- What makes the symptom worse?
  _____
- What makes the symptom better?
  _____
- Does the pain radiate? ☐ Yes ☐ No
- If yes, describe in detail where it radiates _____
- Does the pain feel worse at a particular time of day?
  ☐ Morning ☐ Afternoon ☐ Early evening ☐ Late at night
  ☐ Unchanged by time of day

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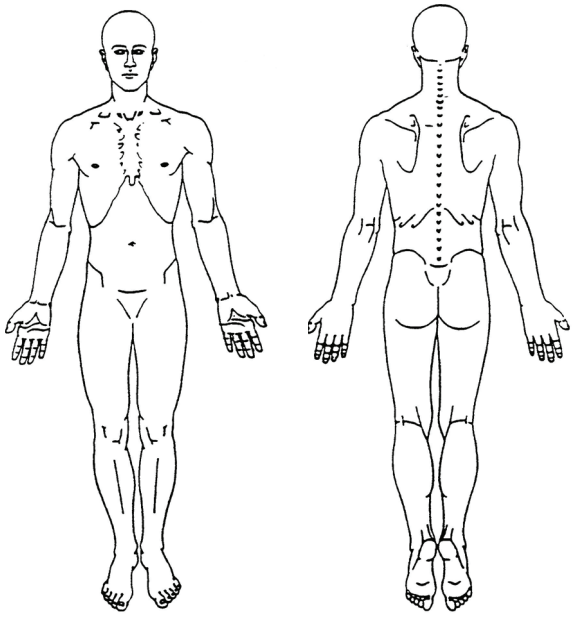

History of Health Concerns

Symptom 3: _____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptom?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
  0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? _____
- Did it begin: ☐ Suddenly ☐ Gradually
- Describe how it began _____
  _____
- Have you had the symptom in the past before? ☐ Yes ☐ No
- If yes, when was the first time you've ever felt the symptom:
  _____
- What makes the symptom worse?
  _____
- What makes the symptom better?
  _____
- Does the pain radiate? ☐ Yes ☐ No
- If yes, describe in detail where it radiates _____
- Does the pain feel worse at a particular time of day?
  ☐ Morning ☐ Afternoon ☐ Early evening ☐ Late at night
  ☐ Unchanged by time of day

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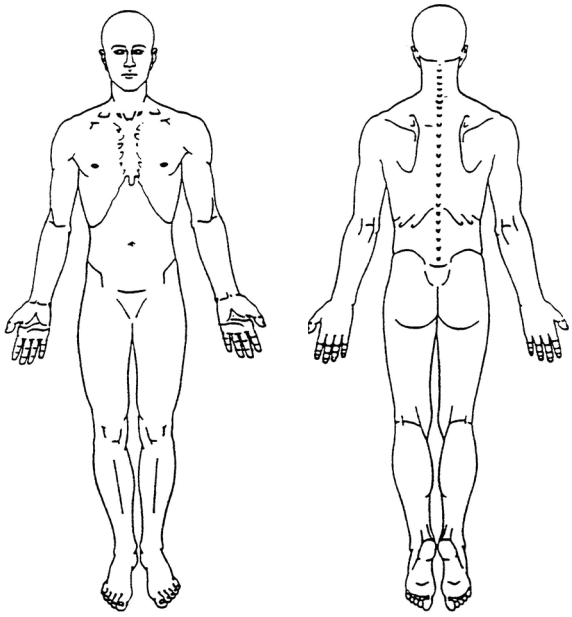

Symptom 4: _____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptom?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
  0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? _____
- Did it begin: ☐ Suddenly ☐ Gradually
- Describe how it began _____
  _____
- Have you had the symptom in the past before? ☐ Yes ☐ No
- If yes, when was the first time you've ever felt the symptom:
  _____
- What makes the symptom worse?
  _____
- What makes the symptom better?
  _____
- Does the pain radiate? ☐ Yes ☐ No
- If yes, describe in detail where it radiates _____
- Does the pain feel worse at a particular time of day?
  ☐ Morning ☐ Afternoon ☐ Early evening ☐ Late at night
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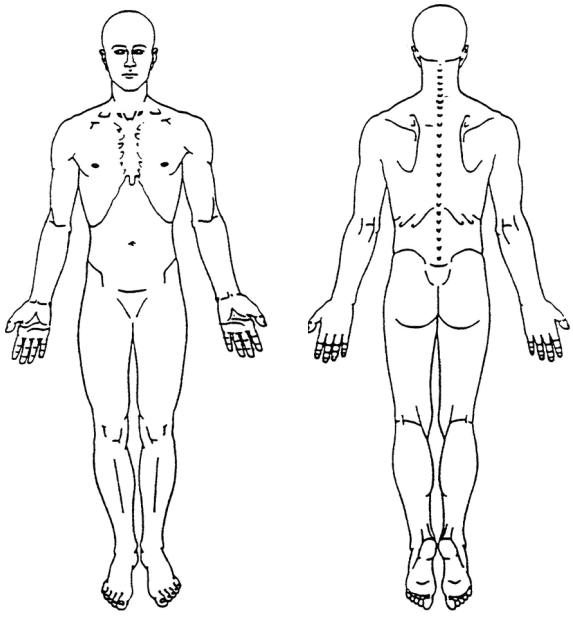

Name_____ Date_____ Jerry Hsieh, DC, Intero Chiropractic, 4847 Hopyard Road, Suite 1, Pleasanton CA 94588

Quadruple Visual Analogue Scale

//Please read carefully//

Instructions: Please circle the number that best describes the question being asked. ***Note**: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each compliant. Please indicate your pain level right now, average pain, and pain at its best and worst.*

***Example:**

A: headache B: neck C: low back

A:_____ **B:**_____ **C:**_____

1. What is your pain **RIGHT NOW**?

No pain 0 1 2 3 4 5 6 7 8 9 10 ***Worst Possible Pain***

2. What is your **TYPICAL** or **AVERAGE** pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 ***Worst Possible Pain***

3. What is your pain level **AT ITS BEST?**
(How close to "0" does your pain get at its best?

No pain 0 1 2 3 4 5 6 7 8 9 10 ***Worst Possible Pain***

4. What is your pain level **AT ITS WORST?**
(How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 ***Worst Possible Pain***

Other comments:

_____

_____

_____

Examiner

Reprinted from *Spine,* 18, Von Korff M, Deyo RA, Cherkinh D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activities	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Carrying Groceries				
Lifting Groceries				
Sit to Stand				
Climbing Stairs				
Pet Care				
Driving				
Extending Computer Use				
Household Chores				
Lifting Children				
Concentration (Reading)				
Bathing				
Dressing				
Shaving				
Sexual Activities				
Sleep				
Static Sitting				
Static Standing				
Yard Work				
Walking				
Washing/Bathing				
Sweeping/Vacuuming				
Dishes				
Laundry				
Garbage				
Dressing				
Other:				

*Patient Signature*_____ *Date* _____

Social History

1. **Smoking:** ☐ cigars ☐ pipe ☐ cigarettes → **How often?** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. **Alcoholic Beverage:** consumption occurs → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. **Recreational Drug Use:** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. **Hobbies**: How does your present problem affect the following: ☐ Recreational Activities ☐ Exercise Regime
   Please Explain:_____

Family History

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No
   If yes whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister's ☐ Brother's ☐ Son(s) ☐ Daughter(s)
   How they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes:_____

Notice of Privacy Practices Acknowledgement

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you.

Permitted Disclosures:

- Treatment purposes- discussion with other health care providers involved in your care
- Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
- For payment purposes - to obtain payment from your insurance company or any other collateral source.
- For workers compensation purposes- to process a claim or aid in investigation
- Emergency- in the event of a medical emergency we may notify a family member
- For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
- To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
- For military, national security, prisoner and government benefits purposes.
- Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
- Telephone calls or emails and appointment reminders - we may call your home and leave voice/text messages regarding an appointment, a missed appointment or apprize you of changes in practice hours or up coming events.
- Announcing names in queue at the front desk & reception area – we announce the first and last names of patients in queue that are waiting to be treated (eg: "Jane Smith, please proceed to room 2"). Please notify the office manager if you would like this to be changed.
- Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

Your rights:

- To receive an accounting of disclosures
- To receive a paper copy of the comprehensive "Detail" Privacy Notice
- To request mailings to an address different than residence
- To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.

*Patient Signature*_____ *Date* _____

Terms of Acceptance

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is essential for both parties to be working toward the same objective. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

- Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. It is not the practice of medicine.
- Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustments of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times a day with doctors of chiropractic in the United States alone.
- Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

Informed Consent For Chiropractic Care

Chiropractic Care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is 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 one million TC one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions. Your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, and 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 examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Jerry Hsieh, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

*Print Name*_____ *Signature*_____ *Date* _____

If this health profile is for a minor/child, please fill out and sign below.

*Name of Practice Member Who is a Minor/Child*_____

I authorize Dr. Jerry Hsieh, DC and any and all Intero Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority care is revoked or altered, I will immediately notify Intero Chiropractic.

*Guardian Signature*_____ *Guardian Relationship to Child*_____ *Date*_____

Family Health History *This form is to assist the doctors by providing past health history information for their review.*

CONDTION	FATHER	MOTHER	SPOUSE	SISTER(S)	BROTHER(S)	CHILDREN
Arm Pain						
Arthritis						
Asthma						
ADD/ADHD						
Allergies						
Back Trouble						
Bed Wetting						
Cancer						
Carpal Tunnel						
Diabetes						
Digestive Problems						
Disc Problems						
Ear Infections						
Fibromyalgia						
Headaches						
Heartburn						
High Blood Pressure						
Hip Pain						
Leg Pain						
Menstrual Disorder						
Migraines						
Neck Pain						
Scoliosis						
Shoulder Pain						
Sinus Trouble						
TMJ						

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files.

At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15. This fee must be paid in advance.

Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day.

Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor of Intero Chiropractic does not diagnose or treat medical conditions. However, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions.

*Print your Name*_____ *Date* _____

*Signature*_____ *Your Age* _____

Female Patients Only:
To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time x-rays are taken at Intero Chiropractic.

*Signature*_____ *Date* _____