Chiropractic ~ Health History

1414 Soquel Avenue #102 ~ Santa Cruz Ca, 95060
(831) 531- 7449
drmichellebean@gmail.com

Name (please print):_____ Date:_____

Address:_____ City:_____ State: _____

Zip: _____ E-mail Address: _____

Birth Date: _____ Age _____

Height _____ Weight_____ Who may we thank for referring you _____

Home Phone: _____ Work Phone: _____

Name of Employer _____Occupation: _____

Marital Status: S M D W # of children: _____

Spouse/Partner Name _____ Spouse/Partner Age _____

Financial Information: Who is responsible for this account_____

Reason Seeking Care: _____

Wellness/Health Maintenance YES NO

Accidents: Please list other accidents, include dates. (car, bicycle, motorcycle, sports, falls at work or home)

_____

_____

_____

_____

Surgeries/Conditions: Please list major surgeries, broken bones or conditions, include dates.

_____

_____

_____

_____

Medications: Please list prescription & over-the-counter medications you are currently taking & their purpose.

_____

_____

_____

Have you been to a chiropractor before? YES NO

Briefly describe that experience:

_____

_____

Did the last chiropractor adjust your spine? YES NO

If yes, was there a “popping” sound when they adjusted you? YES NO

If yes please explain to the best of your ability what causes that “popping” sound:

_____

_____

Expectations of care. How many visits to our office do you anticipate? _____

If you are here due to an injury or pain please describe what happened:

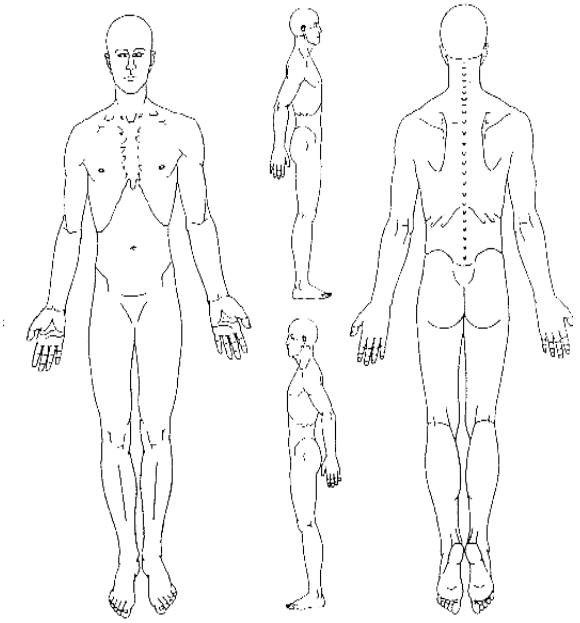
_____

_____

_____

Use the letters below to indicate the type and location of your sensations right now:

A=Ache	B=Burning	N=Numbness
P=Pins & needles	S=Stabbing	O=Other (please describe)



What hurts and how long has it hurt?

1.)_____

2.)_____

3.)_____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1.)_____

2.)_____

3.)_____

Please score all of the following on a scale of 1-10, based on your current condition.

Pain: 1=no pain, 10=worst pain you have ever had _____

Personal care: (washing, dressing, etc.)

1=I can take care of myself with no extra pain, 10=I can't take care of myself at all _____

Lifting: 1=I can lift with no extra pain, 10=I can't lift at all due to _____

Reading: 1=I can read with no extra pain, 10= I can't read at all due to pain _____

Headaches: 1=no headaches, 10=worst headaches I have ever had _____

Concentration: 1=I can concentrate fully, 10=I can't concentrate at all _____

Work: 1=I can work as much as I want, 10=I can't work at all _____

Driving: 1=I can drive with no pain, 10=I can't drive due to pain _____

Sleeping: 1=I sleep fine, 10=I can't sleep at all _____

If you CAN POSSIBLY answer YES, circle YES If you MUST answer NO, circle NO

Please answer all questions. If you are not sure do your best.

Has your eyesight blacked out completely?.....YES NO

Have you fainted more than twice in your life? YES NO

Were you ever knocked unconscious?.....YES NO

Are you hard of hearing? YES NO

Do you have allergies?.....YES NO

Have you ever coughed up blood? YES NO

Have you suffered frequent cramps in your legs? ..... YES NO

Has a doctor ever said you had heart problems? YES NO

Has a doctor ever said you had ulcers?.....YES NO

Does pressure or pain in your head often make life miserable? YES NO

Have you or a family member ever had convulsions or epilepsy? Who?.....YES NO

Did a doctor ever treat you for a tumor or cancer? YES NO

Are you frequently ill?..... YES NO

Are you considered a nervous person? YES NO

Has a doctor ever said your blood pressure was too high.....YES NO

Have you been told you have osteoporosis? YES NO

Have you been told you have rheumatoid arthritis?..... YES NO

Health Survey

In our chiropractic office we provide many services for your health. To get an idea of what you want and expect please take the following survey.

How would you rate your current health? Poor Fair Average Good Excellent

Do you want to live a long & healthy life? Yes No

If you answered yes above, how much time per day outside our office are you willing to commit to this goal?

_____hours _____minutes

Please score yourself from 1 to 10 below in each health category and then indicate if you are interested in receiving help in these areas. You can select as many or as few as you like.

Musculoskeletal pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)

I would like help and/or info on decreasing my pain: Yes No

Diet and nutrition: 1 2 3 4 5 6 7 8 9 10 (1 horrible diet, 10 excellent diet) I would like help and/or info on improving my diet and nutrition: Yes No

Exercise program: 1 2 3 4 5 6 7 8 9 10 (1 horrible exercise habits, 10 excellent exercise habits) I would like help and/or info on exercise: Yes No

Ability to sleep well: 1 2 3 4 5 6 7 8 9 10 (1 horrible sleeper, 10 excellent sleeper) I would like help and/or info on getting a good nights sleep: Yes No

Stress level:1 2 3 4 5 6 7 8 9 10(1 no stress at all,10 extreme stress) I would like help and/or info on decreasing my stress: Yes No

Headache frequency: 1 2 3 4 5 6 7 8 9 10 (1 constant headaches, 10 never) I would like help and/or info on decreasing my headaches: Yes No

Pharmaceutical drug intake: 1 2 3 4 5 6 7 8 9 10 (1 daily intake, 10 never) I would like help and/or info on alternative solutions: Yes No

EnergyLevel:1 2 3 4 5 6 7 8 9 10(1 no energy at all, 10 endless energy) I would like help and/or info on increasing my energy level: Yes No

Other areas of health that you may need help:

_____

_____

_____

Sign:_____ Date:_____

Print Name: _____

Dr. Michelle Bean

1414 Soquel Ave, #102, Santa Cruz CA

HIPAA Notice of Privacy and Confidentiality & Patient's Rights

Patients' rights under HIPAA are described in the "Notice of Privacy Practices" The Notice will be made available to patients. These rights include:

1. Right to receive the 'Notice of Privacy Practices", which informs patients of their rights and how to exercise them. By law this notice is to be made available to patients, and a good faith effort to obtain the patient's acknowledgement of receipt is required.

2. Right of Access. Patients may request to inspect their medical record and may request copies. There may be a fee to produce the copiers. The process to follow and how to request copies is explained in the "Notice of Privacy Practices."

3. Right to Request and Amendment or Addendum. The Notice describes how to file a request for an amendment or addendum.

4. Right to an Accounting of Disclosures. Patients have the right to receive an accounting of disclosures of their Patient Health Information (PHI). The Notice describes how to request an accounting.

5. Right to Request Restrictions. Patients have the right to request restrictions on how they will be communicated with or how their PHI is released. Generally, every effort to try to accommodate reasonable requests for restrictions, e.g., where release of information could be harmful to the patient.

6. Right to Complain. Patients have the right to complain if they think that privacy rights have been violated. The "Notice of Privacy Practices" describes where to file a complaint.

Exceptions to the Rules

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.

Notice of HIPAA Privacy Practice

The attached Notice describes how health information about you may be used, and your rights, regarding the use of that information. Please review it carefully.

You have the right to:

• Ask to see, read and/or obtain a copy of your health record (charges may be necessary)
• Ask to correct information that you believe is wrong in your health record
• Ask that your health information not be used for certain purposes, for example, research
• Ask that copies of your health record be sent to whomever you wish (charges may be necessary)
• Be informed about who has read your record (for reasons other than treatment, payment, and program improvement purposes). • Specify where and how you should be contacted

• Receive a paper copy of the full Notice of Privacy Practices

Who is authorized to see confidential Patient Health Information (PHI)?

The "Notice of Privacy Practices" describes the ways in which your PHI may be used without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted.
1. Treatment of the patient, such as consultation between treating providers
2. Payment of health care bills (insurance claim submission, authorizations and payment posting)

3. Health care operations and business operations, including research (when approved by the IRB and with a patient's written permission); health care communications between a patient and their health care practitioner.

Written Authorizations
To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refer to the "Notice of Privacy Practices" for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. If you do not understand or know what you can do with PHI, please read the "Notice of Privacy Practices".

Exceptions to the Rules

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If you have concerns about how your health information might be (or has been) shared, please speak with your practitioner or the privacy coordinator. If you believe your privacy rights have NOT been maintained you may file a complaint with the Secretary, the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

• I acknowledge receipt of the "Notice of Privacy Practices" and "Patient's Rights". I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the full Notice.
• I understand and acknowledge that I may receive appointment reminder calls, newsletters, and cards, and I agree to receive these.

Signature_____ Date_____

Date of Birth_____

Printed Name_____

Relation (if other than the patient)_____

Patient declined to sign receipt (signature of practitioner)_____

Patient unable to sign (witness signature)_____

Reason unable_____

Michelle C. Bean, Chiropractic

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/ or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION.
HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____

DATED THIS ____ DAY OF _____, 20___

_____ _____
Patient Signature Doctor's Signature

_____
Print Name:

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for
Patient: _____ Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for
Patient: _____
Signature: _____
Relationship to Patient: _____

Remarks:

X-RAY CONSENT FORM

Dr. Michelle Bean -
1414 Soquel Driven #102, Santa Cruz Ca 9506 -
(831)531-7449

Patient: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. In order to perform x-rays on any patient our office requires that patients consent for such tests to be performed.

Please choose one of the following:

____ I understand that the doctor may need x-rays in order to administer my treatment and I give my permission to perform such tests.

____ I understand that it may be necessary for the doctor to take x-rays to administer my care. I choose not to have any x-rays at this time and release the doctor of all liabilities. I also understand that the doctor has the right to refuse treatment to me if I choose this option.

Consent To X-Ray A Minor:

I am the parent or legal guardian of _____, who is a minor, ____years of age. I hereby authorize the performance of diagnostic x-rays of the minor named above. Freeport Family Chiropractic has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am **NOT** pregnant. The doctor and certified staff of Freeport Family Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

	YES	NO	DON'T KNOW
I am pregnant			
I could be pregnant			
My menstrual period is late			
I have an IUD			
I have had a tubal ligation			
I have had a hysterectomy			
I have irregular menstrual periods			

Signed: _____ Date: _____