Name:____Date: ______________________

Address:____

SS#: ____________________________Date of Birth: ____________________ Medicare: ____Yes ____ No

Email: __________________________________ Occupation: ____

☐ Please add me to your email list for appointment reminders, health info., and news.

Male: ____ Female: ____ Marital Status: _____________ # of Pregnancies_________ Children: ________

Spouse's Name: ____

Person to Contact in Case of Emergency: _____________________________________#_____________________

How did you hear about us? ____

Do you have any open cases in these categories:

____ Motor Vehicle Accident/Personal Injury ____ Work Comp Injury

Please describe: ____

List the 5 main reasons for your appointment today (in order of importance):

1. ____

2. ____

3. ____

4. ____

5. ____

☐ Surgeries

☐ Accidents/Injuries

☐ Hospitalizations

Dates: Descriptions:

____

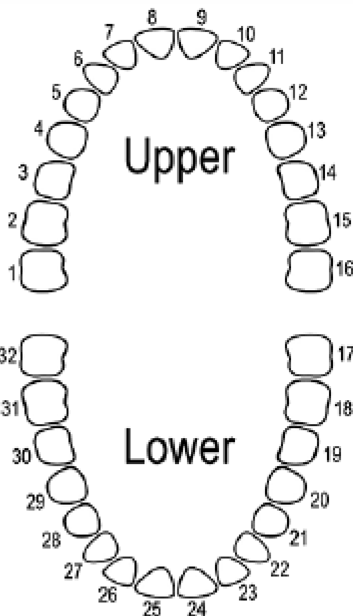
____

____

Medications, Vitamins, Herbs:

____

____



Dental History:

Please mark any current or past areas with: cavities, fillings, implants, crowns, root canal, or other dental surgeries.

X –Current Cavity

XX-Filled

IMP-Implant

C-Crown

RC-Root canal

Orthodontics:

___ Current ___Past

Any additional information you would like to share:

____

____

____

____

____

____

____

____

____

PATIENT: ______________________________ DATE: ___________________________

PATIENT HISTORY

1. What is your **main complaint?** ________________________________
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

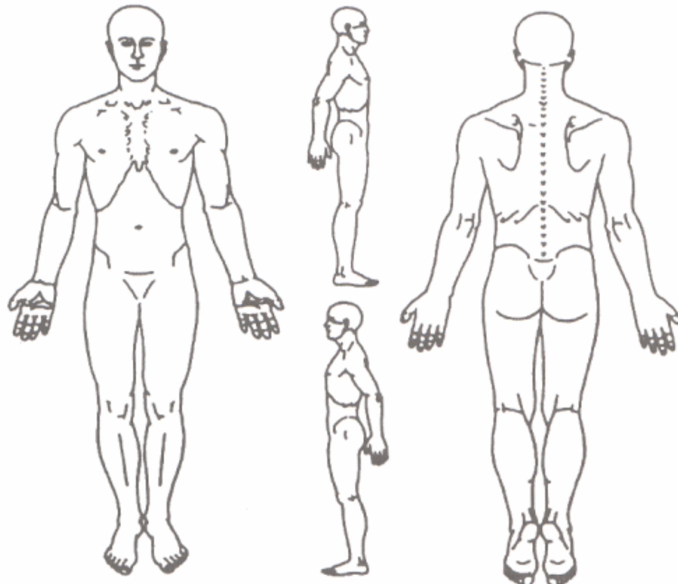
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

		Occasional			*Intermittent*		*Frequent*			*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** ________
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ☐ AM ☐ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? ________________________________
8. What makes it feel worse? ________________________________
9. Have you ever had this problem in the past? ☐ Yes ☐ No
10. I have ☐ been hospitalized ☐ been treated by another chiropractor ☐ been treated by another specialty provider ☐ never received care for this problem.
11. Have you lost time from work because of it? ☐ Yes ☐ No
    Dates?_____________ to _____________
12. Are you Pregnant? ☐ Yes ☐ No Date Due ___________
13. What was the first day of your last menstrual cycle? ___________
14. Number of pregnancies? _______ Miscarriages? _____________

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____
standing ____
social life ____

Signature:________________

Date: ____/____/____

Health History

Check any of the following conditions <u>You</u> have had:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anxiety/depression
- ☐ Arm/shoulder pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Cancer type _________
- ☐ Chronic fatigue
- ☐ Deafness
- ☐ Diabetes
- ☐ Digestion problems
- ☐ Earache
- ☐ Ear ringing
- ☐ Epilepsy
- ☐ Headaches
- ☐ Headaches-migraine
- ☐ Heart disease
- ☐ Hemorrhoids
- ☐ Herniated disc
- ☐ High blood pressure
- ☐ Insomnia
- ☐ Irregular cycle
- ☐ Kidney problems
- ☐ Leg pain
- ☐ Low back pain
- ☐ Neck pain
- ☐ Osteoporosis
- ☐ Poor circulation
- ☐ Prostate problems
- ☐ Rheumatoid arthritis
- ☐ Sciatica
- ☐ Shingles
- ☐ Sinus infection
- ☐ Stroke
- ☐ Thyroid problems
- ☐ TMJ
- ☐ Venereal disease
- ☐ Vertigo/dizziness

Females: Are you pregnant? ____ Yes ____ No

Check any of the following conditions that a <u>Family Member</u> has had:

- ☐ Cancer
- ☐ Rheumatoid arthritis
- ☐ Diabetes
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Epilepsy
- ☐ Chronic back problems
- ☐ Chronic headaches
- ☐ Lupus
- ☐ Other_______________

Stressors: please circle

Smoking Packs/Day ___________________

Alcohol Drinks/Week _________________

Coffee/Caffeine Drinks Cups/Day_________________

Stress level None Moderate Heavy Cause: ____________________

Exercise (please circle): None Moderate Heavy

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition.

Name: ____ Date: ______________________

Signature: ____ Date: ______________________

Informed Consent

By signing this form, you are consenting to an examination by Dr. Robles, D.C. Dr. Robles employs standard chiropractic examination methods including the following:

Observations: General assessment/appraisal in all positions.

Inspection: Viewing/looking at our body parts. Visualization including general body viewing in standard positions: front, back, and sides. All symptomatic (painful) body pars may be viewed.

Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.

Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity of tissues, integrity, and orthopedic/neurological testing; these are standard tests to access your neuromusculoskeletal systems.

NOTE: You do not have to submit to any examination procedure. I ask you to comply to the best of your ability and report changes in your pain. All procedures are accomplished to your tolerance. Please let me know if you are uncomfortable with any examination or treatment procedure.

I, ____ understand the above agreement
(print name)

and agree to submit to the procedures and accept the risks and consequences of their application.

Signature: ____   Date: _________________

Fee Schedule

Initial Appointment (For new patients or patients with a gap in care of 1 year or greater)		$200.00
Follow up Appointments	Adults (ages 12+)	$65
	Children	$55
Re-Exam (All ages) (gaps in care 3 months – 1 year) (big health changes, life events, or injury)		$150
Lab Analysis & Report of Findings Appointment		$135
Labs		Varied based on lab needed
Nutrition, Herbs, Homeopathics		Varied based on product needed

Appointments canceled, missed, or rescheduled less than 24 hours in advance will be charged full price.

Print name: ____ Date: ________________

Signature: ____ Date: ________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THISINFORMATION. PLEASE REVIEW IT CAREFULLY.

Dr. Robles, D.C. is required by law to maintain the privacy and confidentiality of your protected health information and provide our patients with notices of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your health information: Treatment:

We ay disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, and healthcare operations. (Example)

1. If it becomes necessary to seek consultation regarding your condition from other health care providers associated with Dr. Robles
2. Health professionals and/or staff working with Dr. Robles to provide you with care.
3. If Dr. Robles has an emergency absence and you accept a recommendation from Dr. Robles to a substitute healthcare provider.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health operations. (Example)

1. Upon request, Dr. Robles will provide an itemized billing statement. This statement contains medical information including diagnosis, date of injury r condition, and codes which describe the health care services you received.
2. When you submit to your insurance for reimbursement, your insurance company may ask for copies of your health records.

Emergencies:

We may disclose your health information a necessary in the event of an emergency.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes relate to preventing injury or disability, reporting child or elder abuse or neglect, reporting domestic violence, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding. If the California Chiropractic Board of Examiners demands access to our patient records, we are required to provide access.

Law Enforcement

We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing persons, complying with a court order or subpoena or other law enforcement purposes.

Public Safety

Wit may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious or imminent threat to the health or safety of a particular person or the general public.

Marketing

We may contact you for marketing purposes, or fundraising purposes, as describe below:

As a courtesy, Dr. Robles will occasionally call to check in with patients whom she has not seen for a time. We may also contact you for an even sponsored by us. If you are not at home, we will leave message on your answering machine or with the person answering the phone. No personal health information will be disclosed during the recording or message other than that the person calling is, or is working for, Dr. Robles along with a request to call our office.

Change of Ownership

In the event that Dr. Roles sells or merges her business with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Dr. Robles is not required to agree to the restriction that you requested.

You have the right to have your health information received and communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your written request. You understand and accept that the method you request may not be HIPAA (Health Insurance Portability and Accountability Act) and/or GDPR (General Data Protection Regulation) compliant. This means that you accept responsibility for the fact that you are requesting that your personal health information be sent in a way that may not ensure your privacy.

You have the right to inspect and copy your health information.

You have the right to request that Dr. Robles amend your protected health information. Please be advised, however, that Dr. Robles is not required to agree to amend your protected health information. If your r request to amend your health information is denied, you will be provided with an explanation of your denial reason(s).

You have the right to receive an accounting of disclosures of your protected health information made by Dr. robles.

You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Dr. Robles reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all the information that it maintains. Until such amendment is made, Dr. Robles is required by law to comply with this Notice.

Dr. Robles is required by law to maintain the privacy of your health information and provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our office by calling: 916-755-3522.

Complaints

Complaints about your Privacy rights, or how Dr. Robles has handled your health information should be directed to Dr. Robles by calling the office at: 916-755-3522. If you are to satisfied with the manner in which our office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights

Room 509F HHH building

Washington, DC 20201

This notice is effective as of 4/21/19.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Dr. Robles with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.

Printed name: ____ Date: ______________

Signature: ____ Date: ______________

Authorized Facility Signature: ____ Date: ______________