University Chiropractic

Today's Date: _____

1. **PAPER FUN**...to help us get to know you, your lifestyle and health history...to customize a care plan that is a solution for your health personal needs, wants and life.
2. **EXAMINATION**...focused on identifying the CAUSE of interferences and disturbances that have lead to your reason for being here today and how they influence your function, adaptability, health, and lifestyle.
3. **SOLUTIONS**...On your second visit we'll review your findings and let you know if we can help.

Name: _____Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell #: _____

E-Mail Address: _____ Social Security Number: _____

Employer: _____ Occupation: _____ ☐Married ☐Single ☐Widowed ☐Divorced

Name of Spouse: _____ Spouse's Employer: _____

Names and Ages of your children: _____

_____

Name and Phone # of Emergency Contact: _____ Relationship: _____

Who referred you to our office?_____

Who is responsible for your bill: ☐ Self ☐ Spouse☐ Parent ☐ Workman's Comp. ☐ Auto Insurance ☐ Medicare

Insurance Carrier_____ ID _____ Provider #_____

What is your primary complaint? (Please be SPECIFIC): _____

Please check reasons for pursuing chiropractic care:

I'm continuing ongoing care from another chiropractor.
I'm interested in wellness and natural health care.
I'm concerned about my health and I'm looking for answers.
I have no idea why I'm here. Please take the time to explain to me what you do.

TYPE OF CARE

People visit the Chiropractor for a variety of reasons. Some go for symptomatic relief of pain or discomfort. This is called **Relief Care**. Others are interested in having the cause of the problem as well as the symptoms corrected and relieved. This is called **Corrective Care**. Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care. This is called **Wellness Care**. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes when possible.

☐ **Relief** ☐ **Corrective** ☐ **Wellness** ☐ **Doctor to Select**

HISTORY OF YOUR CONDITON

What is the reason for your visit? (please be specific) _____

_____

Have you suffered with this before or a similar problem in the past? ☐ Yes ☐ No If yes how many times? __

When was the last episode? _____ How did the injury happen? _____

[redacted]

HOW DOES YOUR CONDITION EFFECT YOUR LIFE

What is the AVERAGE level of the problem you experience in a typical day?

Completely able to function — Totally unable to function

0 1 2 3 4 5 6 7 8 9 10

What is the LOWEST level of the problem you experience in a typical day?

Completely able to function — Totally unable to function

0 1 2 3 4 5 6 7 8 9 10

What is the HIGHEST level of the problem you experience in a typical day?

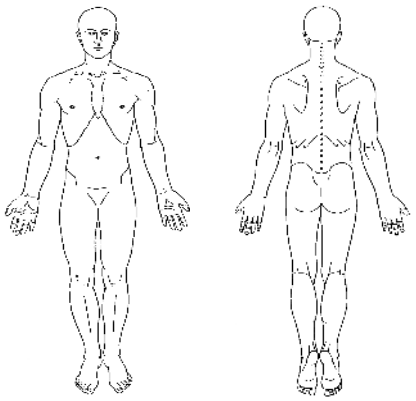
Completely able to function — Totally unable to function

0 1 2 3 4 5 6 7 8 9 10

When you have the problem what percent of the day is it present?

Completely able to function — Totally unable to function

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



How many days a week do you have the problem? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Is it worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Other

_____

Overall, is your condition: ☐ Staying the same ☐ Getting better ☐ Getting worse

How does it interfere with your activities?: ☐ Annoyance ☐ Tolerable ☐ Significant ☐ Complete

What aggravates this condition?

Pulling	Anger	Carrying	Emotional Upset
Pushing	Standing	Sleeping	Driving
Reclining	Stooping	Lifting	Sitting
Repetitive Movement	Straining at Toilet	Throwing	In/Out of Bed
Sneezing	Stress	Turn Head left	In/Out of Car
Rising From Chair	Swimming	Turn Head Right	
Coughing	Climbing Ladder	Walking	
Depression	Climbing Stairs	Walking Up Hill	

Does this cause:	Does this affect your work:	Does this affect your life:
Moodiness	Decision Making	Lose Patience With Spouse Or Children

Irritability	Poor Attitude	Restricted Household Duties
Interrupted Sleep	Decreased Productivity	Effects Ability to Exercise Or Participate In Sports
Restricted Activities	Exhausted At End Of Day	Interferes With Ability To Participate In Hobbies Or Other Desired Activities
	Unable To Work Long Hours	

What makes your condition feel better?

Resting	Elevation	Chiropractic Adjustments
Rubbing Heat Liniment	Exercising	Tylenol/ Advil
Rubbing Mineral Ice	Reclining	Aspirin
Sitting	Pain Pills	Cold
Sleeping	Bending	Exercise
Heat	Hot Showers	

For this condition have you ever sought the services of:

Acupuncturist	Massage	Naturopath	Yoga Studio	Chiropractor
Homeopath	Physical Trainer	Nutritionist	Medical Doctor	Dentist
Optometrist	Physical Therapy	Pediatrician	Psychologist	Psychiatrist

PERSONAL HEALTH PROFILE

Do you currently:

Exercise… ____ / Week
Smoke…____ / Day
Drink Coffee
Take Supplements / herbs / vitamins
Drink Alcohol
Other _____

Do you have any other medical condition other than that which you are now consulting us? ☐ Yes ☐ No

(if yes explain): _____

What **NON-PRESCRIPTION(s)** are you taking? _____

What **PRESCRIPTION(s)** are you taking? _____

Have you or any family members previously had chiropractic care? ☐ Yes ☐ No
Frequency of visits: _____ times a ☐ week ☐ month Duration of care: _____ ☐ weeks ☐ months

Have you or do any members of your family had/have: ☐ Heart Trouble ☐ High Blood Pressure ☐ Diabetes
☐ Arthritis ☐ Back Problems ☐ Cancer Other: _____

Have you been told you have spinal curvature, spinal arthritis, or inherited spinal conditions? ☐ Yes ☐ No

How would you rate your health: Never felt worse - ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 - Feel great!

Are you healthier than you were 5 years ago? ☐ Yes ☐ No

On a scale of 1 to 10, ten being the highest, rate your commitment to getting rid of this problem._____/10

Please check any of the conditions you have suffered from in the last 6 months.

- Headaches
- Migraine Headaches
- Nervous Breakdown
- Depression
- Anxiety
- ADD/ADHD
- Insomnia
- Dizziness
- Seizures
- Fainting Spells
- Sinus Problems
- Allergies
- Runny Nose
- Chronic/Frequent Colds
- Chronic/Frequent Flu
- Hoarseness
- Sore Throat
- Thyroid Conditions
- Chronic Tiredness
- Vision Disturbances
- Issues With Tonsils
- Sore Throat
- Stiff Neck
- Hearing Problems
- Ear Ache
- Shoulder/Arm Pain
- Shoulder/Arm Tingling
- Shoulder/Arm Numbness

Heart Attacks/Angina
Tachycardia
Heart Palpitations
Heart Murmurs
High Blood Pressure
Low Blood Pressure
Pain Wrist/Hand/Finger
Tingling Wrist/Hand/Finger
Numbness Wrist/Hand/Finger
Weakness In Arm Or Hand
Middle Back Pain
Pain Into Your Ribs/Chest
Pain On Deep Breathing
Congestion
Shortness Of Breath
Congestion
Chronic Cough
Asthma
Gall Bladder Conditions
Liver Conditions
Heartburn
Ulcers
Nausea

- Indigestion
- Nervous Stomach
- Other Stomach Problems
- Diabetes
- Hypoglycemia
- Pancreas Problems
- Immune Problems
- Cancer
- Infections
- Allergies
- Hives

Chronic/Frequent Flue
Chronic/Frequent Fever
Adrenal Gland Problems
Spleen Issues
Skin Conditions
Acne
Eczema Or Dry Skin
Kidney Problems
Low Back Pain
Sciatica
Pain In Your Hips/Legs/Feet
Numbness/Tingling In Your Legs/Feet
Coldness In Your Legs/Feet
Cramps In Legs/Feet
Constipation
Diarrhea
Weakness/Injuries In Your Hips/Legs/Ankles
Poor Circulation In The Legs
Swollen Ankles
Weak Ankles & Arches
Weakness In Legs
Restless Legs
Bladder Troubles

- Recurrent Bladder Infections
- Painful Periods
- Irregular Periods
- Miscarriages
- Bed Wetting
- Impotency
- Painful Or Frequent Urination
- Difficulty Urinating
- Sexual Dysfunction
- Hemorrhoids
- Sacro-Iliac Conditions
- Spinal Curvatures
- Scoliosis
- Pain At The End Of The Spine when Sitting

Was your birth:

- Forceps or Suction

Cord around the neck
Drug induced
"C" section
Breech

Have you, (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision, or near collision?

Automobile/Bus
Motorcycle/ Moped/ bicycle
Train/ Airplane
Other vehicles:_____

Work Posture: (during the day)

Sit
Stand
Walk
Do desk work
Phone work
Drive
Heavy lifting
Do mechanical work

Have you ever had a fall, even if you think you were not hurt:

From a crib/Bed
Stroller
Down or up steps/stairs
Chair pulled out from under

Health Care Procedures: Have you ever had a:

Spinal Injection
Spinal Tap Work
Extensive Dental Work
Ever On Crutches
Bifocals
Heel Lifts
Corrective shoes or bars on shoes
Neck Collar
Ever used a walker/cane
Body part in a cast or immobilized

Physical Traumas:

Physical fight
Banged your head
Play a musical instrument
Particular position for watching TV
Sports
Had a Broken Bone
Been knocked unconscious?
Bad Jolt or Impact
Dislocations
Read for prolonged period

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at University Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ *Initials*

REGARDING: X-Rays/Imaging Studies

FEMALES ONLY *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

□ The first day of my last menstrual cycle was on ____-____-____ Date

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____*Initials*

NOTICE OF PRIVACY PRACTICES

I have received a copy of University Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Authorization for Use and Disclosure of Health Information Type of information to be released: Video images, photographic images, verbal and/or written testimonials and statements.

_____ _____

Patient signature Date

OUR OFFICE POLICIES

WELCOME TO UNIVERSITY CHIROPRACTIC

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY –** Since the majority of patient care takes place in an individual or open area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

□ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at University Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use 1)Spinal Manipulation OR 2) a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

□ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

□ **PATIENT'S REPORT OF FINDINGS –** To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Note: Patient retains the above Notice of Office Policies and University Chiropractic retains the signature sheet.

University Chiropractic Notice Of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. 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. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. 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.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. 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.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. 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.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call our office at 650-326-9812. If Dr. Kiser or the Clinic Director is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building