UNWIND Chiropractic Care

1189 Huntington Dr. Ste A Duarte, CA 91010

Patient Intake Form

Name: _____ DOB: ____/____/____ Cel #: _____

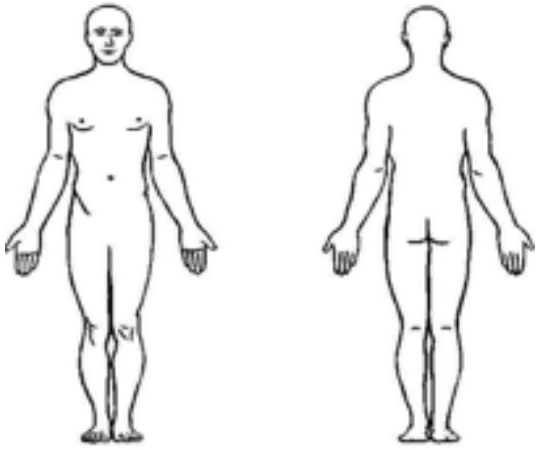
Email: _____

Address: _____

1. Please circle (on right) where you have pain.

Please list your symptoms

1. _____
2. _____
3. _____
4. _____



2. What is the quality of your pain?

◊ Sharp ◊ Dull ◊ Burning
◊ Stiff ◊ Diffuse ◊ Tingly
◊ Stabbing ◊ Achy ◊ Shooting
◊ Numbness ◊ Other _____

3. How often do you experience your symptoms?

◊ 0 – 25% (Intermittently)
◊ 26 – 50% (Occasionally)
◊ 51 – 75% (Frequently)
◊ 76-%100% (Constantly)

4. How are your pain changing with time?

◊ Getting Worse
◊ Not Changing
◊ Getting Better

5. Using a scale from 0 – 10 (10 being the worst), how would you rate your problem? _____

6. How much as the problem interfered with your work?

◊ Not at all ◊ A little bit ◊ Moderately ◊ Quite a bit ◊ A lot

7. How much as the problem interfered with your social activities?

◊ Not at all ◊ A little bit ◊ Moderately ◊ Quite a bit ◊ A lot

8. Who else have you seen for your problem?

◊ Chiropractor ◊ Neurologist ◊ Orthopedist ◊ Physician
◊ Physical Therapist ◊ No one

9. How long have you had this problem? _____

10. What makes the pain worse? _____

11. What makes the pain better? _____

12. How would you rate your overall health?

◊ Excellent ◊ Very Good ◊ Good ◊ Fair ◊ Poor

13. What type of exercise do you do?

◊ Strenuous ◊ Moderate ◊ Light ◊ None

14. Indicate if you have any Immediate Family members with any of the following:

◊ Rheumatoid Arthritis ◊ Diabetes ◊ Hypertension ◊ Heart Problems
◊ Cancer◊ Other _____

15. What treatment have you already received for your condition?

_____

16. Please Circle if you have had any of the following?

◊ AIDS/HIV	◊ Cancer	◊ Hepatitis	◊ Osteoporosis
◊ Alcoholism	◊ Diabetes	◊ Hernia	◊ Pacemaker
◊ Allergy Shots	◊ Emphysema	◊ Herniated disk	◊ Parkinson's Disease
◊ Anemia	◊ Epilepsy	◊ Herpes	◊ Rheumatoid Arthritis
◊ Anorexia	◊ Fractures	◊ Hypertension	◊ STD
◊ Appendicitis	◊ Glaucoma	◊ Stroke	◊ High Cholesterol
◊ Asthma	◊ Gonorrhea	◊ Kidney Disease	◊ Tonsillitis
◊ Bleeding Disorders	◊ Gout	◊ Liver Disease	◊ Tuberculosis
◊ Bronchitis	◊ Heart Disease	◊ Migraine HA	◊ Ulcers

17. Do you smoke? YES NO #/Day _____

18. Are you pregnant? YES / Due Date _____ NO Possible

19. Please list all medications you are currently taking:

_____

20. List all surgical procedures you have had and what year:

_____

21. Have you ever been hospitalized? YES NO
If yes, state your reasons: _____

22. Have you ever seen a chiropractor? YES NO
When: _____

23. Have you had significant trauma or injury? YES NO
Describe: _____

Print Patient Name _____

Parent's or Guardian's Signature: _____

Patient Signature _____ Date: _____

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may us and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Unwind Chiropractic Care

1189 Huntington Dr. Ste A

Duarte, CA 91010

(626) 210-2428

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your

IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths.
- Reporting child abuse or neglect.
- Preventing or controlling disease, injury or disability.
- Notifying a person regarding potential exposure to a communicable disease.
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- Reporting reactions to drugs or problems with products or devices.
- Notifying individuals if a product or device they may be using has been recalled.
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted from criminal conduct.
- Regarding criminal conduct at our offices.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.

- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator).

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

Print Patient Name _____

Parent's or Guardian's Signature: _____

Patient Signature _____ Date: _____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, massage and stretch therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic, massage therapists, and any support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Patient Name _____

Parent’s or Guardian’s Signature: _____

Patient Signature _____ Date: _____