Willow Glen Chiropractic

Patient Intake Form

Name: _____ Date of Birth: _____ Age: _____

SSN: _____ Gender: Male Female Other: _____

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

Home Phone: _____ Mobile Phone: _____

Email Address: _____ Marital Status: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance Coverage (if applicable):

Insurance Carrier:_____ Member ID: _____

Policy Holder's name: _____Policy Holder's birthday: _____ Relationship to patient:_____

Complete this section if you are seeking treatment for an AUTOMOBILE ACCIDENT.

Date of accident: _____ Time: _____ Location: _____

YOUR Auto Insurance Carrier: _____ Claim #: _____

Name of Adjuster: _____ Phone: _____

THEIR Auto Insurance Carrier: _____ Claim #: _____

THEIR name: _____ Phone: _____

Name of Adjuster: _____ Phone: _____

Primary Complaints:

What is bothering you most today:

_____

_____

When did it start: _____

Has the condition been getting better, worse, or stayed the same: _____

What makes it feel better: _____

What makes it feel worse: _____

Have you received treatment for this condition by other specialists: _____

Have you had this or similar conditions in the past? _____

Severity: no pain 1 2 3 4 5 6 7 8 9 10 severe pain

Frequency: occasional (under 25%) intermittent (25-50%) frequently (50-75%) constantly (over 90%)

Quality of pain: aching burning tingling soreness tightness
pins & needles limited motion loss of sensation

Personal Health History:

Please check if you have or have had any of the following conditions.

General:	**Gastrointestinal**	**Respiratory**
❑ Anemia	❑ Abdominal pain	❑ Chest pain
❑ Arthritis	❑ Bloated abdomen	❑ Chronic cough
❑ Asthma	❑ Bloody stool	❑ Difficulty breathing
❑ Cancer	❑ Colitis / Crohn's	❑ Wheezing
❑ Diabetes	❑ Constipation	
❑ Eczema	❑ Diarrhea	**Eyes, Ears, Nose, Throat**
❑ Emphysema	❑ Diverticulosis	❑ Deafness
❑ Epilepsy	❑ Hemorrhoids	❑ Difficulty swallowing
❑ Gout	❑ Liver problems	❑ Earache
❑ Heart disease	❑ Nausea	❑ Eye pain
❑ Hepatitis	❑ Painful defecation	❑ Hoarseness
❑ High cholesterol	❑ Poor appetite	❑ Sinus infections
❑ Hypertension	❑ Vomiting	❑ Ringing in ears
❑ Infection blood / bone		
❑ Multiple Sclerosis	**Genitourinary**	**Cardiovascular**
❑ Numbness / tingling	❑ Blood in urine	❑ High blood pressure
❑ Osteoporosis	❑ Difficulty urinating	❑ Low blood pressure
❑ Pacemaker	❑ Frequent urination	❑ Hardening of arteries
❑ Pneumonia	❑ Incontinence	❑ Poor circulation
❑ Rheumatic fever	❑ Kidney infections	❑ Rapid heartbeat
❑ Stroke	❑ Kidney stones	❑ Slow heartbeat
❑ Thyroid disease	❑ Painful urination	❑ Swelling of ankles
❑ Ulcers		

Any blood relatives with the following conditions:

❑ Anemia	❑ Cancer	❑ Osteoporosis
❑ Arteriosclerosis	❑ Diabetes	❑ Stroke
❑ Arthritis	❑ Heart disease	❑ Thyroid disease

Please list all that apply:

Medications _____

Allergies _____

Hospitalizations _____

Accidents _____

Surgeries _____

Broken bones _____

Strain/sprains _____

Disclosure of Your Health Care Information

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include: emergency care, quality assurance activities, public health, research and law-enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and/or receive copies of your records within 30 days of a request. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you via mail, email or telephone for appointment reminders, announcements, and to inform you about our practice and its staff. If we call and can't speak to you directly, we may leave a message if necessary; either with the person who answered the phone, or as a recorded message.

Our practice is required to abide by this notice. We have the right to make changes to this notice in the future.

Questions or complaints about your privacy rights, or how this office has handled your health information, should be directed to Dr. I-Ching Hsieh. If you are not satisfied with the manner in which your complaint is handled, you may submit a formal complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

I have read this disclosure and understand my rights contained in this privacy notice. By way of my signature, I provide Dr. I-Ching Hsieh with my authorization and consent to use and disclose my protected healthcare information for the purpose of treatment, payment and health care operations as described in the privacy notice.

PATIENT / GUARDIAN NAME (print): _____

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

Assignment of Benefits

I hereby grant and assign the benefits that I am eligible to receive for professional services rendered in this office to Dr. I-Ching Hsieh. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. It is also important that you understand, as with all type of health care approaches, results are not guaranteed. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.

2.) There are rare reported cases of stroke associated with visits to chiropractors. Researches have shown that the risk of stroke from a chiropractic visit is no greater than the risk from visiting a medical doctor. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

3.) Other complications may include fractures, disc injuries, dislocations, muscle strain/sprain, costovertebral strains/sprain, and burns from electrical stimulation.

4.) Your chiropractor will make every effort to screen for any contraindications to care during the history, examination, and x-ray (if warranted); however, if you have a condition (eg. underlying weakness of the bone or tissue such as osteoporosis and/or degenerated discs) that would otherwise not come to their attention, it is your responsibility to inform them.

Dr. Hsieh will consider the benefits and risks of each treatment option and advise you on the best treatment plan for your condition.

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

PATIENT / GUARDIAN NAME (print): _____

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

WITNESS NAME (print): _____

WITNESS SIGNATURE: _____ DATE: _____