CHIROPRACTIC

SPORTS THERAPY

CENTER

PATIENT RECORD

PATIENT INFORMATION

DATE

Name Phone Email

Marital Status Single Married Separated Divorced Widowed

Address

Date of Birth Age Sex Male Female

Social Security # Driver's License #

Occupation

Employer Phone

Employer's Address

SPOUSE INFORMATION

Name Phone

Employer Phone

Employer's Address

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name

Parent/Relative Phone #

INSURANCE INFORMATION

Primary Insurance Group/Policy #

Insured's Name Social Security #

2nd Insurance Group/Policy #

Insured's Name Social Security #

Auto Insurance Policy #

Insured's Name Social Security #

WHOM MAY WE THANK FOR REFERRING YOU?

PATIENT'S SIGNATURE

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PRIVACY NOTICE

Chiropractic Sports Therapy is required by law to maintain the privacy of your health information and to 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 Manager at 714.771.7171. If not immediately available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

COMPLAINTS:

Complaints about your Privacy Rights, or how Chiropractic Sports Therapy has handled your health information should be directed to our Office Manager by calling this office at 714.771.7171. If not immediately available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW
Room 509F HHH Building
Washington DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide Chiropractic Sports Therapy with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (please print) _____

Patient Signature _____ Date _____

Authorized Facility Signature _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Chiropractic Sports Therapy's NOTICE OF PRIVACY PRACTICES revision date _____.

As required by the Privacy Regulations, _____, a staff member from Chiropractic Sports Therapy has explained the NOTICE OF PRIVACY PRACTICES to my satisfaction.

As required by the Privacy Regulations, I am aware that Chiropractic Sports Therapy has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

REQUESTS:

_____ I wish to file a REQUEST FOR RESTRICTION of my Protected Health Information

_____ I wish to file a REQUEST FOR ALTERNATIVE COMMUNICATIONS of my Protected Health Information

_____ I wish to object to the following in the NOTICE OF PRIVACY PRACTICES

_____

_____

I understand that this office is not required to honor any changes to the NOTICE OF PRIVACY PRACTICES.

Patient Name (please print)

Patient Signature

Date

OFFICE USE ONLY

Signed form received by Date

Good faith effort to obtain receipt (Describe)

CHIROPRACTIC
SPORTS THERAPY
CENTER

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Chiropractic Sports Therapy.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor or intern, affiliated with Chiropractic Sports Therapy to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) Date

_____

Patient or Guardian's Signature

CHIROPRACTIC

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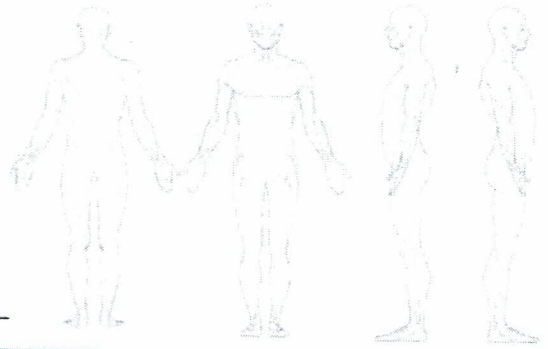
CONFIDENTIAL CASE HISTORY

PATIENT NAME _____ **TODAY'S DATE** _____

1. What is your chief complaint? If more than one, list the worst first):

2. Mark the diagrams below the area(s) of complaint:



3. Which of these apply?
   - Auto Accident/Date:
   - On the job injury/date:
   - Other, describe/include date:

4. Have you received any treatment for this condition? YES / NO
   If so, list what, when and by whom & your opinion of the results:

5. How did this condition develop?

6. Have you ever had anything similar to this before? YES / NO If yes, when?

7. Does it radiate to any other part of your body? YES / NO If yes, where?

8. Can you qualify what you feel? DULL ACHING SHARP STABBING STIFF BURNING
   THROBBING SHOOTING NUMBNESS TINGLING OTHER

9. Is it constant or does it come and go?

10. Has it been getting? BETTER / WORSE / ABOUT THE SAME Over what period of time?

11. What makes it feel better?

12. What makes it feel worse?

PAST MEDICAL HISTORY

1. Have you had any recent illness? YES / NO If yes, describe, include date:

2. List your surgeries / diseases with dates:

3. Most recent set of x-rays: DATE DR. / FACILITY
   WHERE TAKEN VIEWS TAKEN

4. Have you ever had any major falls/blows to the body? YES / NO If yes, describe / include date

5. Have you ever broken any bones? YES / NO If yes describe / include date

6. Have you ever had any strains or sprains? YES / NO If yes describe / include date

7. Have you ever been in an automobile accident? YES / NO If yes describe / include date

DOCTOR'S NOTES

SYMPTOM SURVEY

Please mark all symptoms, past and present

MUSCLES & BONES

- ☐ Low Back Pain
- ☐ Pain between shoulders
- ☐ Head/neck problems
- ☐ Arm problems
- ☐ Leg problems
- ☐ Foot/ankle problems
- ☐ Jaw pain/clicking
- ☐ Hand/wrist problems
- ☐ Hip problems
- ☐ Muscles weak/sore
- ☐ Shoulder problems
- ☐ Walking problems
- ☐ Knee problems
- ☐ Arthritis pain
- ☐ Muscle cramps
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint popping
- ☐ Joint grinding
- ☐ Loss of joint motion

NERVOUS SYSTEMS

- ☐ Numbness/tingling
- ☐ Fatigue
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Cold feet/hands
- ☐ Confusion
- ☐ Irritability/tension
- ☐ Depression
- ☐ Crying spells
- ☐ Loss of feeling
- ☐ Loss of balance
- ☐ Loss of coordination
- ☐ Convulsions
- ☐ Paralysis

HEART & LUNGS

- ☐ Chest pains
- ☐ Shortness of breath
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins
- ☐ Hiatal hernia

EYES, EARS, NOSE & THROAT

- ☐ Wear glasses/contacts
- ☐ Ear pain
- ☐ Ear noises/ringing
- ☐ Dental problems
- ☐ Throat problems
- ☐ Thyroid problems
- ☐ Sinus problems
- ☐ Nasal problems
- ☐ Nose bleeds
- ☐ Last eye exam
- ☐ Light bothers eyes
- ☐ Halos around lights
- ☐ Spots in eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of hearing
- ☐ Ear infections
- ☐ Allergies
- ☐ Frequent colds
- ☐ Loss of smell/taste
- ☐ Hoarseness
- ☐ Gagging
- ☐ Choking
- ☐ Difficulty swallowing
- ☐ Gums sore/bleeding

URINARY TRACT

- ☐ Bladder problems
- ☐ Pain urinating
- ☐ Difficulty urinating
- ☐ Change in frequency of urination
- ☐ Discolored urine
- ☐ Prostate problems

STOMACHS & INTESTINES

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Crave sweets
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Belching
- ☐ Vomiting
- ☐ Indigestion/heartburn
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Gas
- ☐ Constipation
- ☐ Black stool
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gall bladder problems
- ☐ Overweight
- ☐ Underweight

GENERAL

- ☐ Fatigue
- ☐ Sleeping difficulty
- ☐ Recurrent colds/infections
- ☐ Skin changes
- ☐ Lumps/lymph glands swelling
- ☐ Forgetfulness
- ☐ Nervousness
- ☐ Bruise easily
- ☐ Asthma

FEMALE

- ☐ Irregular bleeding
- ☐ Genital pain
- ☐ Breast pain
- ☐ Lumps on breast
- ☐ Menstrual cramps
- ☐ Hot flashes
- ☐ Irregular periods
- ☐ Recurrent infections
- ☐ Problem pregnancies
- ☐ Hysterectomy
- ☐ Discharge

Date of last period: _____

Breast exam: _____

Self exam: _____

Is there any possibility you're pregnant? YES NO

CHILDREN

- ☐ Learning difficulties
- ☐ Over active
- ☐ Coordination problems
- ☐ Recurrent infection
- ☐ Sensitives to food or medications

OTHER

MISCELLANEOUS

What medications/vitamins are you taking?

Any other drugs? Even over the counter?

Do you sleep primarily on your? BACK SIDE STOMACH Normal hours of sleep?

Do you have a regular exercise program? YES NO What? How often?

Do you have a well-balanced diet of variety of foods? YES NO

Please rate your stress level: (1=no stress, 10=excessive stress) PERSONAL LIFE JOB

Does your employment require SITTING WRITING TYPING STANDING LIFTING BENDING WALKING DRIVING

FAMILY HISTORY

(Answer the following with F=Father, M=Mother, B=Brother, S=Sister, O=Other)

- ☐ Diabetes
- ☐ Cancer
- ☐ Lung disease
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hypoglycemia
- ☐ Other, describe _____

NOTES

_____

I declare that I have answered the above truthfully and to the best of my knowledge.

Patient's Signature **Date**

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DAILY ACTIVITIES AND PAIN SCALE QUESTIONNAIRE

PATIENT NAME **TODAY'S DATE**

Mark each of the activities which you have difficulty performing and/or can perform only with pain.
For difficulty - use the letter **D**. For pain - use the letter **P**. For difficulty with pain - use **DP**.

HOUSEWORK

____ Doing Laundry
____ Making Beds
____ Vacuuming
____ Washing Dishes
____ Ironing
____ Carrying Groceries
____ Caring for Pets
____ Cooking
____ Other, Please list below

YARD WORK

____ Mowing lawn
____ Shoveling snow
____ Raking leaves
____ Gardening
____ Other, Please list below

ACTIVE

____ Exercising
____ Swimming
____ Other, Please list below

GENERAL

____ Walking
____ Standing
____ Running
____ Sitting
____ Sitting in recliner
____ Lifting
____ Bending
____ Pulling
____ Pushing
____ Kneeling
____ Climbing Stairs
____ Reading
____ Using telephone
____ Chewing
____ Lying in Bed
____ Sleeping
____ Sexual intercourse
____ Getting up from chair/bed
____ Playing piano
____ Using computer/ typewriter
____ Other, Please list below

PERSONAL GROOMING

____ Combing hair
____ Shaving
____ In/Out of Bathtub
____ Brushing Teeth
____ Other, Please list below

TRAVEL

____ Driving
____ Riding (passenger)
____ Minutes / day in each type of vehicle
____ Auto
____ Train
____ Bus
____ Truck
____ Airplane
____ Getting in and out of auto
____ Other, Please list below

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose.

PAIN SEVERITY SCALE

Please state the area of pain. (If more than one area, please indicate and mark each area individually.)
Rate the severity of your pain by marking one box on the following scale:

NO PAIN | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | EXCRUCIATING PAIN

PATIENT'S SIGNATURE **DATE**

CHIROPRACTIC SPORTS THERAPY CENTER

Dr. Kenneth A. Nilsson

Doctor of Chiropractic · Certified Chiropractic Sports Physician · Qualified Medical Examiner

1421 East Chapman Avenue, Orange, CA 92866 · 26151 Marguerite Parkway, Mission Viejo, CA 92692

714.771.7171

PATIENT INFORMATION VERIFICATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL: _____

NO SHOW POLICY UPDATE:

We understand that there are times when you must miss an appointment due to an emergency or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a forty dollar ($40) fee.

SIGNATURE _____ DATE _____