

# PATIENT'S PRESENT COMPLAINTS

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_ Social Security# \_\_\_\_\_ Driver Lic.# \_\_\_\_\_  
 Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M / F Status M S W D No. Children \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Years Employed \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
 Person Responsible for this Account \_\_\_\_\_ Health Plan \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: \_\_\_\_/\_\_\_\_/\_\_\_\_

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

How often are your symptoms present?  Constantly  Frequently  Occasionally  Intermittently

Describe your current pain/symptoms:

<input type="checkbox"/> Sharp/Stabbing	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Aches
<input type="checkbox"/> Dull	<input type="checkbox"/> Soreness	<input type="checkbox"/> Weakness
<input type="checkbox"/> Numbness	<input type="checkbox"/> Shooting	<input type="checkbox"/> Gripping
<input type="checkbox"/> Burning	<input type="checkbox"/> Tingling	<input type="checkbox"/> Other _____

Since it began, is your problem:  Improving  Getting Worse  No Change

What makes the problem better?

<input type="checkbox"/> Nothing	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Movement
<input type="checkbox"/> Exercise	<input type="checkbox"/> Inactivity/rest	<input type="checkbox"/> Other _____

What makes the problem worse?

<input type="checkbox"/> Nothing	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Movement
<input type="checkbox"/> Exercise	<input type="checkbox"/> Inactivity/rest	<input type="checkbox"/> Other _____

Can you perform your daily home activities?  Yes  Yes, only with help  Not at all

Do you exercise?  Yes, almost daily  Yes, occasionally  Not at all

Describe your job requirements:  Mainly sitting  Light Labor  Heavy Labor

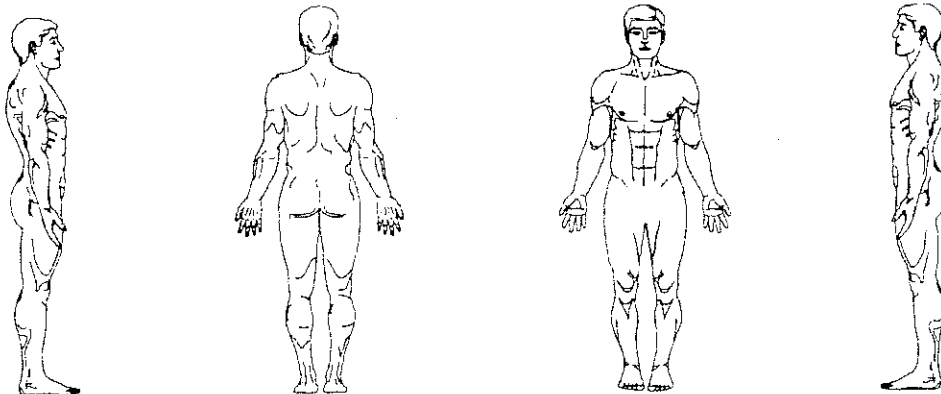
Can you perform your daily work activities?  Yes, all activities  Only some  Not at all

Describe your stress level:  None to mild  Moderate  High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

Have you had X-rays, MRI or other tests for this condition? What tests and When? \_\_\_\_\_

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# PATIENT'S HEALTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Patient ID# \_\_\_\_\_

If you have ever had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

<b>Past</b>	<b>Present</b>	<b>Condition</b>	<b>Past</b>	<b>Present</b>	<b>Condition</b>
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Liver / Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
		<input type="checkbox"/> Gain <input type="checkbox"/> Loss	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	If a family member has had any of the following, please mark the appropriate box:		
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue			
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow			
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow			
<input type="checkbox"/>	<input type="checkbox"/>	Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps			
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis			
<input type="checkbox"/>	<input type="checkbox"/>	PMS			
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control			
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination			
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination			
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing			
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion			
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash			
			<input type="checkbox"/>	<input type="checkbox"/>	Cancer
			<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
			<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
			<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
			<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems
			<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
			<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Back Problems
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Headaches
			<input type="checkbox"/>	<input type="checkbox"/>	Lupus
			<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Present Weight \_\_\_\_\_ pounds      Height \_\_\_\_\_ feet \_\_\_\_\_ inches

**Please check any of the following that apply to you**

<b>Past</b>	<b>Present</b>		<b>Past</b>	<b>Present</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # births _____	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills, type _____	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere) _____	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
			<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffinated Soft drinks: cups/cans per day _____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures (list if not described elsewhere) _____			

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 or health plan coverages in the future.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT HISTORY**

Name: \_\_\_\_\_ Referred By: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Social Security #: \_\_\_\_\_ California Driver's License # \_\_\_\_\_  
Email address: \_\_\_\_\_ (YOUR EMAIL ADDRESS WILL NOT BE SHARED WITH ANYONE.)

**PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):**

**MAJOR COMPLAINT**

How long have you had this condition? \_\_\_\_\_  
Have you lost work days because of this condition? Yes ( ) No ( ) How many? \_\_\_\_\_  
Is the injury related to: Work accident ( ) Auto accident ( )  
When have you last seen a chiropractor? \_\_\_\_\_ Dr.: \_\_\_\_\_  
Why did you see this chiropractor? \_\_\_\_\_ Were you helped? \_\_\_\_\_  
What spinal maintenance programs were you given to follow to maximize the future stability of your spine?  
\_\_\_\_\_

Did you follow the program? \_\_\_\_\_ If not, why? \_\_\_\_\_

Why are you changing chiropractors? \_\_\_\_\_

**WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?)** \_\_\_\_\_

**HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?** \_\_\_\_\_

\_\_\_\_\_ Temporary Relief (Help the symptom but do not fix the cause of the problem)

\_\_\_\_\_ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

**WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US?**  
\_\_\_\_\_

What are your favorite activities or hobbies to do now? \_\_\_\_\_

Are your current problems affecting these activities or hobbies? \_\_\_\_\_

What activities are you looking forward to doing in retirement? \_\_\_\_\_

On a scale of 1 – 10 (10 being the most, and 1 being the least):

\_\_\_\_\_ How committed are you to being at your maximum health potential?

\_\_\_\_\_ How important is it for your family to be at their maximum health potential?

\_\_\_\_\_ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? \_\_\_\_\_

List drugs or supplements you now take (prescription & non prescription): \_\_\_\_\_

Name other doctors you have seen for this condition: What was done, and for how long? \_\_\_\_\_

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## INFORMED CONSENT

It is our responsibility to fully inform you of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. It, however, has one of the safest records of the wide range of treatments that can be used for spinal disorders. Please feel free to ask the Doctor if you need any clarification.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on nerve tissue, fractures in weakened bones such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasm or tightening are common but usually brief reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications versus the relative frequency of the complications of the other typical treatments which may be used for a spinal disorder.

**DISC INJURY from manipulation causing spinal cord pressure**  
**1 per 100 million cases**  
**1 per 400 million (cmt)**

**ARTERY INJURY from manipulation causing stroke**  
**1 per 1 million**

**NEUROLOGICAL complication from**  
**Neck Surgery            1 per 64 (cases)**  
**Back Surgery            1 per 333 (cases)**

**DEATH RATE from neck surgery**  
**1 per 145**

Perhaps the most common alternative to spinal manipulation is the use of anti-inflammatory drugs or NSAIDs. These drugs cause fairly common and can also potentially cause serious complications.

<b>COMPLICATIONS ASSOCIATED WITH ANTI-INFLAMMATORY DRUG USE</b>	
Serious stomach or intestinal bleeding	1-4 per 100 users
Hospitalizations from complications	20,000 per year
Deaths from complications	2,600 per year

I have read the above and understand the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Eric Belusa, DC or any DC at Performance Chiropractic.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Disclosure of Fees/ Payment Policy

99201	Brief Initial History and Consultation	60.00
99202	Brief Initial History and Exam	75.00
99203	Intermediate Initial History and Exam	100.00
99204	Comprehensive History and Exam	140.00
99211	Min. Office Visit/ Re-evaluation (not needing doctors presence)	35.00
99212	Brief Office Visit/ Re-evaluation	45.00
99213	Limited Office Visit/ Re-evaluation	55.00
99214	Intermediate Office Visit/ Re-evaluation	80.00
97026	Infrared Hot/ Cold	35.00
97035	Ultrasound/ Iontophoresis 15 minutes or less	45.00
97032	Muscular Stimulation 15 minutes or less	55.00
97124	Vibromassage	15.00
97124	Massage Therapy 15 minutes or less	30.00
97250	Myofascial Release 15 minutes	50.00
99012	Mechanical Traction	30.00
98940	Manipulation 1-2 Areas	60.00
98941	Manipulation 3-4 Areas	75.00
98943	Extra Spinal Manipulation	60.00
98940-52	Office Visit/ Manipulation	55.00
98940-52	Family Wellness Plan	
98940	Medicare Spinal Manipulation 1-2 Areas	29.48
98941	Medicare Spinal Manipulation 3-4 Areas	41.12
98942	Medicare Spinal Manipulation 5 Regions	52.82
72040	X-rays Cervical 2 Views	90.00
72050	X-rays Cervical 5 Views	130.00
72100	X-rays Lumbar 2 Views	100.00
72070	X-rays Thoracic 2 Views	100.00
99070	Brace and Supports	Varies
	Supplements	Varies

I have read the above codes and fees and understand and know the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and co-payments of my care. I further understand that it is my responsibility to know my own insurance benefits and that Performance Chiropractic is not responsible for any discrepancy between what my coverage is and what was reported to us. I understand that if I have a balance for medical services not paid, I will make a minimum payment of \$50.00 each month or 20% (auto debit) of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of the case. I understand that if a check or debit is returned for insufficient funds, I will be charged a \$25.00 service charge.

**I have read and fully understand the above financial terms and prices.**

Signed \_\_\_\_\_ Date \_\_\_\_\_.

## PERFORMANCE CHIROPRACTIC CENTER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Performance Chiropractic Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of Your Health Care Information**

#### **Treatment**

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

*"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Performance Chiropractic Center."*

*"It is our policy to provide a substitute health care provider, authorized by Performance Chiropractic Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

#### **Payment**

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

*"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Performance Chiropractic Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

#### **Workers' Compensation**

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

#### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

#### **Public Health**

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office at 925-687-5515 If Eric Belusa, D.C. is not 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, S.W.  
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 the notice.

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

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

**If you would like the complete document (4 pages), please ask the front desk. Thank you.**

## Health and Medical Information Release Form

I, \_\_\_\_\_, give permission to Dr. Eric Belusa, his staff, associates, and employees of Performance Chiropractic to share private and medical information with my medical doctor, \_\_\_\_\_, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Belusa and his staff.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Patient Info

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Medical Doctor Info

Name of Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_