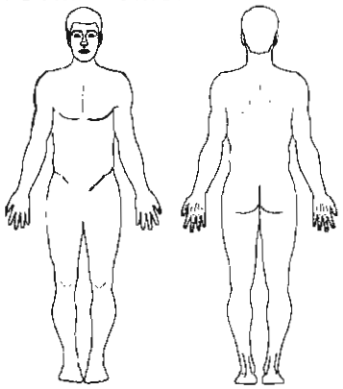
INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name _____ Birthdate _____ Sex M / F
Address _____ City _____
State _____ Zip _____ Telephone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan: _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain
☐ Other _____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began: _____
How Problem Began: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken: _____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) _____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) _____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) _____
_____
_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
_____
_____
☐ Medications _____
_____
_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature _____ **Date** _____

ADDITIONAL PATIENT HISTORY

Name_____ Referred by_____

Social Security Number_____ CA Driver's License_____ Marital Status_____

How would you like us to contact you? Please indicate your preference.

( ) Text_____ ( ) Phone_____
Cell Phone Carrier_____ ( ) Email_____

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give us 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 and 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_____

Name: _____ Date:_____

Email address_____ (this will not be shared with anyone)

The government has mandated that **all** healthcare providers become compliant with electronic health records by 2014. In order for us to better serve you, our office needs specific information so that we can become compliant with these laws. If questions don't apply to you, please indicate with a N/A

*Problem you are seeking care for:

1._____3._____

2._____4._____

*Any Major illnesses?

1._____ 2._____

*Have you been diagnosed as a Type I or Type II diabetic? Y/N

*Have you been diagnosed with hypertension? Y/N Physician:_____

*What is your race/ethnicity? _____

*What is your primary language? _____

*Height_____ Weight _____ Blood Pressure _____/_____ Pulse_____

*Current medications (if additional, please attach a copy of all medications)

1._____3._____

2._____4._____

*Allergies to any medications? Y/N Medication _____

*Are you a current smoker? Y/N Are you a former smoker Y/N

Thank you for your time and understanding in helping us navigate through these new and complicated laws.

Dr. Belusa and staff

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.

COMPLICATIONS ASSOCIATED WITH ANTI-INFLAMMATORY DRUG USE	
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

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

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.