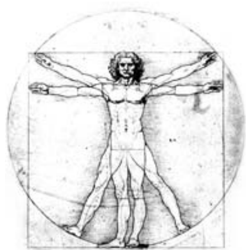
Chiropractic Kinesiology
Physical Therapy Weight Loss
Sports Injuries Exercise Programs
Auto Accidents Physical Exams



Well Being Chiropractic

1700 Eureka Rd Suite 190 Tel: (916)725-7533
Roseville, Ca. 95661 Fax: (916)771-5939

Patient:____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Applied Kinesiology and Wellbeing Chiropractic and his associates/employees for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Applied Kinesiology and Chiropractic. I understand that diagnosis or treatment of me by Applied Kinesiology and Wellbeing Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Wellbeing Chiropractic is not required to agree to the restrictions that I may request. However, if Wellbeing Chiropractic agrees to a restriction that I request, the restriction is binding on Wellbeing Chiropractic and his associates/employees.

I have the right to revoke this consent, in writing, at any time, except to the extent that Wellbeing Chiropractic or his associates/employees have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Wellbeing Chiropractic's Notice of Privacy Practices prior to signing this document. The Wellbeing Chiropractic Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Wellbeing Chiropractic. The Notice of Privacy Practices for Wellbeing Chiropractic is also provided upon request in his office. This Notice of Privacy Practices also describes my rights and Wellbeing Chiropractic's duties with respect to my protected health information.

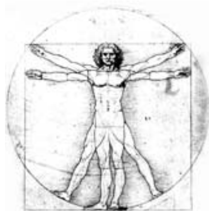
Wellbeing Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative Date

____
Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Chiropractic
Physical Therapy
Sports Injuries
Auto Accidents
Kinesiolgoy
Weight Loss



Well Being Chiropractic

1700 Eureka Rd Suite 190
Roseville, Ca 95661
Tel: (916)771-4151
Fax: (916)771-5939

Patient Information

Patient Name: ____ Date of Birth: _____________ Age: ____

Address: ____ City: _____________ State: _____ Zip: _______

Home Phone: (____)_____________ Mobile Phone: (____)_____________ Work Phone: (____)____________

Soc. Sec. #: _______-_____-________ Drivers License: State_____ # __________________________________

Married: Y / N Name of Spouse: ____________________________ Children: Y / N How many: _________

Occupation/Job: _______________________________________ How Long: ___________________________

Employer: ____ Supervisor's Phone (____)_____________

Work Address: _____________________________________ City: _____________ State: _____ Zip: ________

E-mail address____

Insurance Information

Insurance Company: ____ Phone #: (____)________________

Address: ____ City: _____________ State: _____ Zip: _______

Claim #: ___________________________________ Policy/Group # ___________________________________

Date of Injury: _________________ Was this accident __in an automobile? __at work? __other(_____________)

Has the accident been reported? Y / N To Whom? ____

Insurance Adjustor: ____ Phone #: (____)___________________

Attorney Name: ____ Phone #: (____)___________________

Emergency Contact Information

Whom may we contact in case of an emergency? Name: ____

Relationship: ____________________________ Phone #: (____)_______________, (____)_________________

Address: ____ City: _____________ State: _____ Zip: _______

Primary Physician: ____ Phone #: (____)______________________

Address: ____ City: _____________ State: _____ Zip: _______

Signature: ____ Date: _____________________

CASE HISTORY

Name: ___________________________________
Date of Last Physical Exam: __________ With whom: ______________________Where: ______________________
Report Findings: ____
Surgeries, Hospitalization, Serious Illnesses (list YEAR in brackets): ____
____
____
Fractures, Dislocations, Major Dental Work (list YEAR in brackets): ____
____
____
Ever use Crutches: Y / N Why: ____
Ever: Had Spinal Taps or Spinal Injections: Y / N Been knocked unconscious: Y / N Had a Lapse of Memory: Y / N
Purpose of this Appointment: ____
____
Other Doctors seen for this Condition: ____
Are you currently on medication: Y / N If yes, which ones (put the reason for drug's use in brackets): ____________
____
Known Allergies: ____
Suffer from any conditions other than the reason you are here today: ____

HABITS

Smoke: Y / N What: ____________________ How many/Day: _______ Since when: _______
Other Tobacco Products: Y / N What: ____________________ How many/Day: _______ Since when: _______
Drink Coffee: Y / N Cups/Day: ________________ Water – Cups/Day: _______________________
Drink Caffeinated Tea: Y / N Cups/Day: ________________ Other – Cups/Day: _______________________
Colas/Soft Drinks: Y / N Avg/Week: ___________ What kind(s): ________________________________
Alcoholic Beverages: Y / N Avg/Week: ___________ What kind(s): ________________________________
Eat Red Meat: Y / N What kinds: ____
Vegetarian: Y / N Since when: ________ White or Whole Wheat grains: ______________________
Currently Dieting: Y / N If so, describe: ____
Eat Fast Food: Y / N How often/Week: _______ How do you feel after these meals: ______________
Taking Supplements: Y / N If so, which ones: ____
Sleep well at night: Y / N If no, describe: ____
Exercise: ____ None ____ Light Activity ____ Moderate Activity ____ Active ____Very Active ____ Elite Athlete
Times/Week: _______ Describe Exercise Program: ____
____ Use Heart Rate Monitor: Y / N If yes, target range: _____
Frequent Bowel movements: Y / N Difficulty: Y / N Approximate times you urinate each Day: ________________
Have enough Energy for Normal Activities: Y / N If no, descibe: ____
Height: ______Weight: ______ (Adult Max. Weight): ______ at Age _____ (Adult Min Weight): ______ at Age ____
Has Vision changed recently: Y / N If yes, explain: ____
Wear Heal Lifts / Foot Supports: Y / N If yes, explain: ____

WOMEN ONLY

Age at onset: _____ Are your Periods regular: Y / N Cycle: ______ days (start to finish) Use Birth Control Pill: Y / N
Your Flow is: heavy medium light Date of Last Period: _______ Are Cramps regular: Y / N Is PMS regular: Y / N
If yes (to PMS), describe: ____

Other Mentrual / Hormonal Symptoms: ____

MEDICAL HISTORY

Please mark today's pain intensity level

1 – LOW PAIN
10 – HIGH PAIN

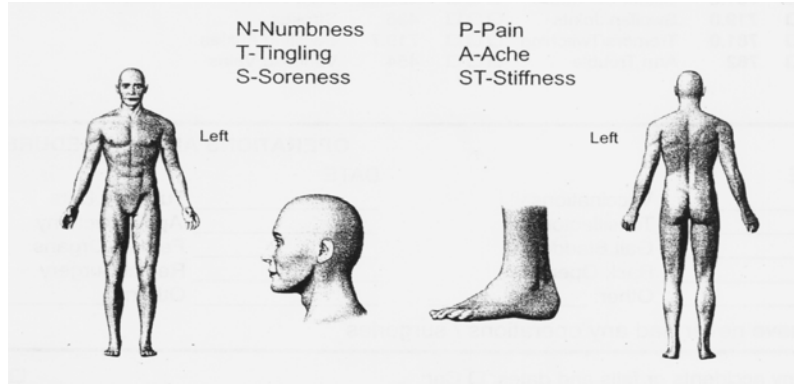
Example: _______________ Neck _______________
1 2 3 4 (5) 6 7 8 9 10

1. ____
1 2 3 4 5 6 7 8 9 10

2. ____
1 2 3 4 5 6 7 8 9 10

3. ____
1 2 3 4 5 6 7 8 9 10

Mark area & type of pain on the drawings using codes listed below



X-RAY HISTORY

Please include CAT / MRI / DYE STUDIES and DENTAL . . . When was most recent PROCEDURE perfomed? ________________________

AGE	BODY AREA	TYPE (NORMAL X-RAY / CAT / MRI / etc.)	# of STUDIES

FAMILY MEDICAL HISTORY

	Living	Age or Age at Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Other Description
Father													
Father's Mother													
Father's Father													
Father's Grandmas													
Father's Grandpas													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Grandmas													
Mother's Grandpas													
Mother's Siblings													
Your Siblings													
Your Children													

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company, and any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon reciept. However, I understand and agree that I am personally responsbile to pay for all services I receive that are not covered by my insurance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as he deems appropriate using Chiropractic Health Care. It is understood and agreed the amount paid the Doctor for X-Ray negatives will remain the property of this office, and may be seen at any time while I am a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's/Guardian's Signature: ____ Date: ____________________