

# CASE HISTORY

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

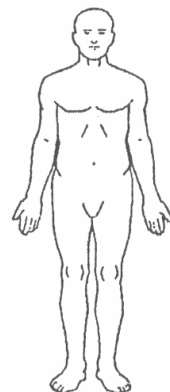
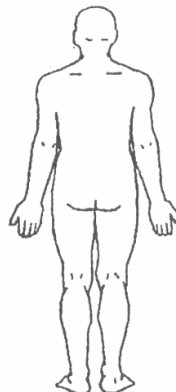
Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Sex:  M  F Marital Status: S  M  D  W   
 # of Children: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Referred by: \_\_\_\_\_  
 Doctor's Name: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Phone (Home): \_\_\_\_\_  
 Phone (Work): \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Appointment reminder preference: Call  Email  Text   
 Spouse's Name: \_\_\_\_\_  
 Spouse's Occupation: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_  
 Spouse's Phone (Cell/Work): \_\_\_\_\_  
 Past Chiropractic Care:  Yes  No When? \_\_\_\_\_  
 Results: \_\_\_\_\_

Chief Complaint 1. \_\_\_\_\_ Duration (How Long): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 List Current 2. \_\_\_\_\_ Duration (How Long): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 Problems 3. \_\_\_\_\_ Duration (How Long): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_

Please mark area and type of pain on the drawings using the codes listed below.

Pain = **P**      Numbness = **N**  
 Stiffness = **ST**      Tingling = **T**  
 Ache = **A**      Soreness = **S**



## HABITS

## EXERCISE

## FAMILY HISTORY

Smoking      Packs/Day: \_\_\_\_\_  
 Drinking      Alcohol: \_\_\_\_\_  
 Coffee      Cups/Day: \_\_\_\_\_  
 High Stress      Reason: \_\_\_\_\_

None  
 Moderate  
 Daily  
 Type: \_\_\_\_\_

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> 541 Appendicitis    | <input type="checkbox"/> 280 Anemia      | <input type="checkbox"/> 429.9 Heart Disease | <input type="checkbox"/> 716 Arthritis        |
| <input type="checkbox"/> 480 Pneumonia       | <input type="checkbox"/> 055 Measles     | <input type="checkbox"/> 345 Epilepsy        | <input type="checkbox"/> 044 HIV Positive     |
| <input type="checkbox"/> 390 Rheumatic Fever | <input type="checkbox"/> 072 Mumps       | <input type="checkbox"/> 319 Mental Disorder | <input type="checkbox"/> 239 Cancer           |
| <input type="checkbox"/> 045 Polio           | <input type="checkbox"/> 052 Chicken Pox | <input type="checkbox"/> 511 Pleurisy        | <input type="checkbox"/> 724.2 Lumbago        |
| <input type="checkbox"/> 011 Tuberculosis    | <input type="checkbox"/> 250 Diabetes    | <input type="checkbox"/> 305.0 Alcoholism    | <input type="checkbox"/> 099 Venereal Disease |

**Please check the correct box for each item below.  
Check at least one box for each sign or symptom listed.**

<p style="text-align: center;"><b>GENERAL SYMPTOMS</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 905.3 Allergy (What) _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.4 Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.2 Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.7 Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.0 Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.0 Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 729.2 Neuralgia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782 Numbness/pain in arms/legs/hands</p> <p style="text-align: center;"><b>SKIN OR ALLERGIES</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 924.9 Bruising Easily</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 691.8 Eczema</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 708.9 Hives or Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.0 Sensitive Skin</p>	<p style="text-align: center;"><b>GASTRO-INTESTINAL</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 789.0 Colon Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 575.9 Gall Bladder Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 455.6 Hemorrhoids (piles)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 794.8 Liver Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.8 Pain over Stomach</p> <p style="text-align: center;"><b>EYE/EAR/NOSE/THROAT</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 493.9 Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 389.9 Deafness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.7 Nose Bleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 379.91 Pain in Eyes</p> <p style="text-align: center;"><b>RESPIRATORY</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.50 Chest Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.09 Difficulty Breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.3 Spitting Blood</p>	<p style="text-align: center;"><b>MUSCLES &amp; JOINTS</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 550.0 Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.1 Pain Between Shoulders</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 724.6 Painful Tailbone</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 781.9 Spinal Curvature</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.0 Swollen Joints</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 781.0 Tremors</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 781.0 Twitching</p> <p style="text-align: center;"><b>CARDIO-VASCULAR</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 401.9 High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 458.9 Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.51 Pain over Heart</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 438 Past Heart Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 436 Strokes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.3 Ankle Swelling</p>	<p style="text-align: center;"><b>GENITO-URINARY</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 599.7 Blood in Urine</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.4 Frequent Urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.3 Inability to Control Urine</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 590.9 Kidney Infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.1 Painful Urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 601.9 Prostate Problems</p> <p style="text-align: center;"><b>FOR WOMEN ONLY</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 625.3 Cramps or Backaches</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 627.2 Hot Flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 626.4 Irregular Cycle</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Currently Pregnant</p> <p>_____ Due Date</p> <p>_____ Last Pap Date</p>
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Prior operations and procedures: \_\_\_\_\_

List any accidents or falls and dates:  Car: \_\_\_\_\_  Recreation Vehicle: \_\_\_\_\_

Sports: \_\_\_\_\_  School: \_\_\_\_\_  Other: \_\_\_\_\_

List any broken bones (fractures) or dislocations: \_\_\_\_\_

Ever on crutches?  Yes  No Why? \_\_\_\_\_

Have you ever had any spinal taps or spinal injections?  Yes  No Were you ever knocked unconscious?  Yes  No

Have you ever had a lapse of memory?  Yes  No

Have you ever had X-rays taken?  Yes  No When? \_\_\_\_\_ By Whom? \_\_\_\_\_

For what ailments were these X-rays made? \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us? \_\_\_\_\_

Are you presently taking any medication – prescription or over the counter?  No  Yes What drugs? \_\_\_\_\_

What are your goals or expectations for your treatment (e.g. decreased pain, increased function, etc.)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account or receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. 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/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. 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.

**I HAVE READ AND UNDERSTAND THE ABOVE**

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

# INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, and physical therapy techniques, for me (or the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment, including but not limited to: muscle sprains and strains, disc injuries, dislocations, broken bones and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based on the facts then known, are in my best interest. I understand that chiropractic treatments are generally considered safe and effective.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose, and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

**Timothy P. Angelo, D.C. C.C.E.P.**  
**Northern California Chiropractic & Sports Therapy**  
**903 Embarcadero Drive, Suite 3**  
**El Dorado Hills, CA 95762**  
**P: (916) 933-9870 • F: (916) 933-3540**

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient's Guardian or Representative**  
**(If patient is a minor or incapacitated)**

\_\_\_\_\_  
**Date**

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

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Translator (if translation required)**

\_\_\_\_\_  
**Date**

# Northern California Chiropractic & Sports Therapy

## 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. Northern California Chiropractic & Sports Therapy 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.

*"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Northern California Chiropractic & Sports Therapy."*

*"It is our policy to provide a substitute health care provider, authorized by Northern California Chiropractic & Sports Therapy 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.

*"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Northern California Chiropractic & Sports Therapy 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:** As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administrative Proceedings:** We may disclose your health information in the course of any administrative or judicial proceeding.

**Law Enforcement:** We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Deceased Persons:** We may disclose your health information to coroners or medical examiners.

**Organ Donation:** We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

**Research:** We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

**Public Safety:** It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

**Specialized Government Agencies:** We may disclose your health information for military, national security, prisoner and government benefits purposes.

**Change of Ownership:** In the event that Northern California Chiropractic & Sports Therapy is sold or merged with another organization, your health information/record will become the property of the new owner.

**Sign in Sheets:** It is our practice to have a sign in sheet at the front desk.

**Courtesy Calls to Your Residence:**

*“As a courtesy to our patients, it is our policy to call your home on the day prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”*

**Your Health Information Rights:**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Northern California Chiropractic & Sports Therapy is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Northern California Chiropractic & Sports Therapy amend your protected health information. Please be advised, however, that Northern California Chiropractic & Sports Therapy is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Northern California Chiropractic & Sports Therapy.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

Northern California Chiropractic & Sports Therapy reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Northern California Chiropractic & Sports Therapy is required by law to comply with this Notice.

Northern California 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: Timothy Angelo by calling this office at 916-933-9870. If Timothy Angelo is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

**Complaints:** Complaints about your Privacy rights, or how Northern California Chiropractic & Sports Therapy has handled your health information should be directed to Timothy Angelo by calling this office at 916-933-9870. If Timothy Angelo 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 04/15/07.

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

By way of my signature, I provide Northern California Chiropractic & Sports Therapy 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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date