CASE HISTORY

Date: _____

Name: _____ Phone (Home): _____

Address: _____ Phone (Work): _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Email: _____

Social Security Number: _____ Appointment reminder preference: Call ☐ Email ☐ Text ☐

Sex: ☐ M ☐ F Marital Status: S ☐ M ☐ D ☐ W ☐ Spouse's Name: _____

# of Children: _____ Spouse's Occupation: _____

Employer: _____ Spouse's Employer: _____

Referred by: _____ Spouse's Phone (Cell/Work): _____

Doctor's Name: _____ Past Chiropractic Care: ☐ Yes ☐ No When? _____

Occupation: _____ Results: _____

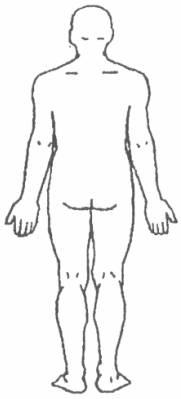
Chief Complaint 1. _____ Duration (How Long): _____ Previous Episodes: _____

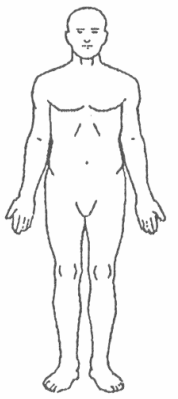
List Current Problems 2. _____ Duration (How Long): _____ Previous Episodes: _____

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

☐Smoking Packs/Day: _____

☐Drinking Alcohol: _____

☐Coffee Cups/Day: _____

☐High Stress Reason: _____

EXERCISE

☐None

☐Moderate

☐Daily

Type: _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, # ___	☐	☐	☐	☐	☐
Sister, # ____	☐	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐ 541 Appendicitis
☐ 480 Pneumonia
☐ 390 Rheumatic Fever
☐ 045 Polio
☐ 011 Tuberculosis

☐ 280 Anemia
☐ 055 Measles
☐ 072 Mumps
☐ 052 Chicken Pox
☐ 250 Diabetes

☐ 429.9 Heart Disease
☐ 345 Epilepsy
☐ 319 Mental Disorder
☐ 511 Pleurisy
☐ 305.0 Alcoholism

☐ 716 Arthritis
☐ 044 HIV Positive
☐ 239 Cancer
☐ 724.2 Lumbago
☐ 099 Venereal Disease

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

Never Present Previous

GENERAL SYMPTOMS
☐☐☐ 905.3 Allergy (What) _____
☐☐☐ 780.4 Dizziness
☐☐☐ 780.2 Fainting
☐☐☐ 780.7 Fatigue
☐☐☐ 784.0 Headache
☐☐☐ 787.0 Nausea
☐☐☐ 729.2 Neuralgia
☐☐☐ 782 Numbness/pain in arms/legs/hands

SKIN OR ALLERGIES
☐☐☐ 924.9 Bruising Easily
☐☐☐ 691.8 Eczema
☐☐☐ 708.9 Hives or Allergy
☐☐☐ 782.0 Sensitive Skin

GASTRO-INTESTINAL
☐☐☐ 789.0 Colon Trouble
☐☐☐ 575.9 Gall Bladder Trouble
☐☐☐ 455.6 Hemorrhoids (piles)
☐☐☐ 794.8 Liver Trouble
☐☐☐ 536.8 Pain over Stomach

EYE/EAR/NOSE/THROAT
☐☐☐ 493.9 Asthma
☐☐☐ 389.9 Deafness
☐☐☐ 784.7 Nose Bleeds
☐☐☐ 379.91 Pain in Eyes

RESPIRATORY
☐☐☐ 786.50 Chest Pain
☐☐☐ 786.09 Difficulty Breathing
☐☐☐ 786.3 Spitting Blood

MUSCLES & JOINTS
☐☐☐ 550.0 Hernia
☐☐☐ 719.1 Pain Between Shoulders
☐☐☐ 724.6 Painful Tailbone
☐☐☐ 781.9 Spinal Curvature
☐☐☐ 719.0 Swollen Joints
☐☐☐ 781.0 Tremors
☐☐☐ 781.0 Twitching

CARDIO-VASCULAR
☐☐☐ 401.9 High Blood Pressure
☐☐☐ 458.9 Low Blood Pressure
☐☐☐ 786.51 Pain over Heart
☐☐☐ 438 Past Heart Trouble
☐☐☐ 436 Strokes
☐☐☐ 782.3 Ankle Swelling

GENITO-URINARY
☐☐☐ 599.7 Blood in Urine
☐☐☐ 788.4 Frequent Urination
☐☐☐ 788.3 Inability to Control Urine
☐☐☐ 590.9 Kidney Infection
☐☐☐ 788.1 Painful Urination
☐☐☐ 601.9 Prostate Problems

FOR WOMEN ONLY
☐☐☐ 625.3 Cramps or Backaches
☐☐☐ 627.2 Hot Flashes
☐☐☐ 626.4 Irregular Cycle
☐ Yes ☐ No Currently Pregnant
_____ Due Date
_____ Last Pap Date

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 Date

_____ _____
Authorized Facility Signature Date