Better Health
CHIROPRACTIC
Life Changing Results

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based rehabilitation that helps our patients recover their optimal health; often where many other systems have failed. Because of this, we may not accept you as a patient until we are absolutely certain we know what is causing your condition, can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations, as well as make certain your healing will be our TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____

PATIENT NAME

_____

DATE COMPLETED

4700 Rocklin Road · Rocklin, CA 95677 · (916) 632-2676
www.bhchiro.com

Patient Information

(Age)_____Gender: M F

Name:_____ Height_____Weight_____

Home Address:_____ Home Phone: ( ) _____

City, State, Zip:_____ Work Phone: ( ) _____

Email Address:_____ Cell Phone: ( ) _____

Birth Date: ____/____/____ Social Security #:_____-_____-_____ Marital Status: S M D W

Occupation: _____ Employer Name:_____

Spouse's Name: _____Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer:_____ Occupation:_____

How were you referred to this office?_____

Purpose For This Visit

Reason for this visit:_____

Is this related to an accident or specific injury (other than auto or work-related)*? ❑ Yes ❑ No If yes, when:____/____/____

If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe:_____

Please use the General Symptoms Chart on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin?____/____/____ Are they: ❑ Constant ❑ Intermittent ❑ Activity-related

Are they getting worse? ❑ Yes ❑ No Do they interfere with: ❑ Work ❑ Sleep ❑ Hobbies ❑ Daily Routine

Explain:_____

What activities aggravate your symptoms?_____

Is there anything that relieves your symptoms? ❑ Yes ❑ No If yes, explain:_____

Have you experienced these symptoms before (if not accident/injury related)? ❑ Yes ❑ No

If yes, explain:_____

Have you been treated for this? ❑ Yes ❑ No When were you last treated?____/____/____

Who did you see?_____

What treatment was performed?_____

How did you respond?_____

Experience with Chiropractic

Have you seen a Chiropractor before? ❑ Yes ❑ No Who?_____

Reason for visit(s):_____

Did your previous chiropractor take 'before' and 'after' x-rays? ❑ Yes ❑ No What was the diagnosis?_____

Did he or she recommend a specific course of treatment? ❑ Yes ❑ No

Did they recommend a Home Health Care program? ❑ Yes ❑ No

If yes, what?_____ How long were you treated?_____ Last treatment:____/____/____

How did you respond?_____

Are you aware of any poor posture habits? ❑ Yes ❑ No Is there any history of spinal problems in your family? ❑ Yes ❑ No

If yes, explain:_____

_____

_____

_____

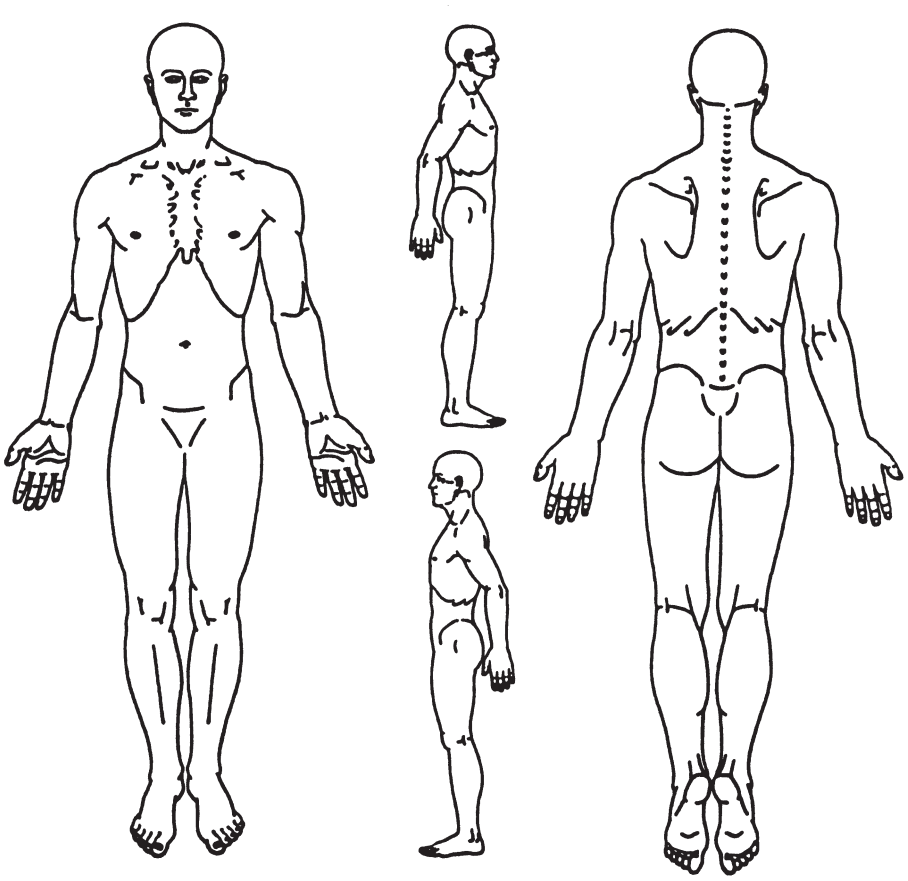
General Pain Disability Index

How long have you had this pain?___Years___Months___Weeks

Is this your first episode of this pain? ❑ Yes ❑ No

Use the letters below to indicate the type and location of your sensations right now

KEY:	A = Ache	B= Burning	N = Numbness
	P = Pins & Needles	S = Stabbing	O = Other



Please rate your pain level by placing an X on the scale below:

Pain level TODAY:

|----------|

Absent Extreme

Average Pain level over the PAST WEEK:

|----------|

Absent Extreme

General Pain Disability Index *continued...*

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating ***overall*** impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES**. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been disrupted or prevented by your pain.

1. Family/Home Responsibilities. This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school.)

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. Recreation. This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. Social Activity. This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. Occupation. This category refers to activities that are part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. Self Care. This category includes activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. Life-Support Activity. This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

Total Score: _____ Signature: _____ Date: _____

Health & Lifestyle

Do you exercise? ❑ Yes ❑ No How often?_____ day(s) per week; Other:_____

What activities? ❑ Walking ❑ Running/Jogging ❑ Weight Training ❑ Cycling ❑ Yoga ❑ Pilates ❑ Swimming

❑ Other:_____

Do you smoke? ❑ Yes ❑ No How much? / How often?_____

Do you drink alcohol? ❑ Yes ❑ No How much? / How often?_____

Do you drink coffee? ❑ Yes ❑ No How much? / How often?_____

Do you take any supplements (i.e. vitamins, minerals, herbs)?_____

If yes, please list:_____

BRAIN HEALTH

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Poor attention span
____ Mental fatigue
____ Difficulty learning new things
____ Floating/halos in vision
____ Low motivation
____ Loss of concentration
____ Inappropriate thoughts
____ Slowed movement
____ Difficulty with balance
____ Easily becoming "car sick" or "sea sick"
____ Memory loss that impacts daily activities
____ Difficulties planning/problem solving
____ Personality/mood changes
____ Difficulty recognizing familiar faces
____ Difficulty remembering events
____ Hearing noises that are not there
____ Difficulty with basic math
____ Twitching/tremors when resting
____ Handwriting has become poor/jerky

CERVICAL SPINE (NECK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Sinusitis
____ Allergies/Hay fever
____ Recurrent colds/Flu
____ Low Energy/Fatigue
____ TMJ/Pain/Clicking

Please explain:_____

_____

_____

THORACIC SPINE (UPPER BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations
____ Heart Murmurs
____ Tachycardia
____ Heart Attacks/Angina
____ Recurrent Lung Infections/Bronchitis
____ Asthma/Wheezing
____ Shortness Of Breath
____ Pain On Deep Inspiration/Expiration

Please explain:_____

_____

_____

Health Conditions *continued...*

THORACIC SPINE (MID BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain ____ Nausea ____ Diabetes

____ Pain in Ribs/Chest ____ Ulcers/Gastritis ____ Hypoglycemia/Hyperglycemia

____ Indigestion/Heartburn ____ Reflux

____ Tired/Irritable after eating or when not having eaten for a while

Please explain:_____

_____

_____

LUMBAR SPINE (LOW BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet ____ Weakness/injuries in hips/knees/ankles ____ Low back pain

____ Numbness/tingling in legs/feet ____ Recurrent bladder infections ____ Coldness in legs/feet

____ Frequent/difficulty urinating ____ Muscle cramps in legs/feet ____ Sexual dysfunction

____ Constipation/Diarrhea ____ Menstrual irregularities/cramping (females)

Please explain:_____

_____

_____

OTHER

Please list any health conditions not mentioned:_____

_____

_____

_____

Please list any medications (include name, dose, for what condition, and how long you've been taking it):_____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed):_____

_____

_____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable):***

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia/Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox/Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago
____ ADD/ADHD	____ Dyslexia	____ Depression	____ Learning Disorder
____ Difficulty Sleeping	____Other:_____		

_____

Authorization of Care

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or staff for all services rendered.

Patient's Signature _____ Date_____ /_____ /_____

Patient's Name Printed_____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded_____County, State of Guardianship_____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date_____ /_____ /_____

In Case of Emergency

Name_____ Relationship_____

Work Phone ( ) _____

Home Phone ( )_____

Cell Phone ( )_____

Primary Care Physician

Name_____

Phone Number ( )_____

Address_____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to Better Health Chiropractic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to Better Health Chiropractic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. Better Health Chiropractic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Better Health Chiropractic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically due and payable.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? ❑ Yes ❑ No

Patient's Signature _____ Date_____ /_____ /_____

Signature of Person Authorizing Care (if different from patient):

_____ Date_____ /_____ /_____

Relationship to Insured _____ Date of Birth_____ /_____ /_____

Employer_____

Primary Insurance Company_____ Policy#_____

Address_____ Phone # ( ) _____

Insured's Name_____ Insured's Social Security #:_____ -_____ -_____

Secondary Insurance Company_____ Policy#_____

Address_____ Phone # ( ) _____

Insured's Name_____ Insured's Social Security #:_____ -_____ -_____

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic names below and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic of office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based up on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by doctor or staff:

Name and address of clinic/office:

Better Health Chiropractic
4700 Rocklin Rd
Rocklin, CA 95677
916-632-2676

_____
Witness to Patient's Signature

_____
Translated By

HIPAA Happenings at Better Health Chiropractic

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise to You, Our Valued Patient...

We want to assure you that we take the new Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now ?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of electronic technology in the health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review how your information is used within our computers, internet, phones, fax machines, and any device used to copy or transfer that data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal health information will be shared only as required for the purpose of administering your care. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we promise our adherence to those laws. We also want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice in order to collect payment for the services provided to you in this office. We may do this with insurance forms filed for you electronically or by mail. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations to our staff. Some of the best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during insurance company audits or by government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy, which is to partner with our patients to see they receive the best chiropractic care we can provide. This may include postcards, newsletters, flyers, and telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).

Public Health and National Security

We may be required to disclose necessary health information to Federal officials or military authorities in order to complete investigations related to public health and or national security.

For Law Enforcement

As permitted or required by State and Federal law, we may disclose your health information under certain circumstances to proper authorities for the purpose of law enforcement. This may take place if you are a victim of a crime, or in order to report a suspected crime.

Family, Friends and Care Givers

We may share your health information with those that assist you with your home hygiene, care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable communicate your wishes, we will use our very best judgement when sharing your health information with anyone participating in your care.

Medical Research
Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories will transpire only under the ethical guidance, requirements, and approval of an Institution Review Board.

Authorization to Use or Disclose Heath Information
Other than the information stated above, or information that Federal, State, and Local laws require, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

Patient Rights
This law is careful to describe that you have rights related to you health Information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications
You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately, with or without other family members present, or through sealed mail communications. We will make all reasonable efforts to honor your request.

Inspect and Copy Your Health **Information**
You have the right to read, review, and copy your health information. This Includes your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested, sealed, and or delivered to any authority for review.

Documentation of Health **Information**
You have the right to request a description of how our office used your health information for reasons other than treatment, payment, or health care operations. Our documentation procedure will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We greatly appreciate your limited request for no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of This Notice
You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. We are required by law to maintain privacy of our health information and provide to you or your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients will be notified of any such changes. You have the right to express concerns or complaints to any staff member of Better Health Chiropractic, or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Patient Acknowledgment

Patient Name(s):

_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledgments that you have received, thoroughly reviewed, and understand this policy by signing on the line below. Thank you.

_____ _____

Patient Signature Date


Better Health
CHIROPRACTIC
Life Changing Results