

PERIPHERAL NEUROPATHY



Better Health
CHIROPRACTIC
Life Changing Results

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our office. We are a very unique team specializing in researched-based peripheral neuropathy treatment that helps our patients recover their optimal health; often where many other systems and treatment 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 office.

PATIENT NAME

DATE COMPLETED

PERIPHERAL NEUROPATHY

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: _____

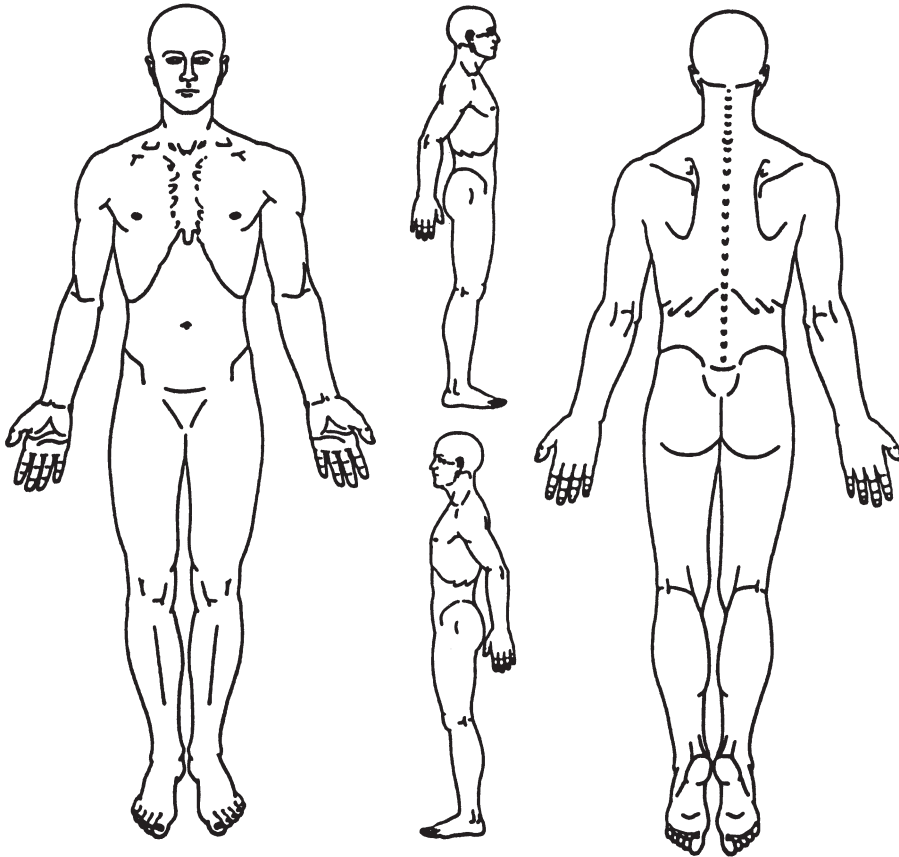
General Pain Disability Index

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 C = Cramping
- P = Pins & Needles S = Stabbing/Shooting Pain O = Other

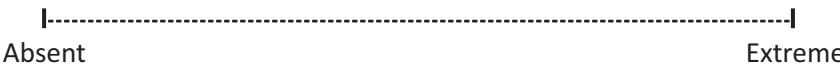


Please rate your pain level by placing an X on the scale below:

Pain level TODAY:



Average Pain level over the PAST WEEK:



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

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.

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

CERVICAL SPINE (NECK)

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

<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Pain in shoulders/arms/hands	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Allergies/Hay fever
<input type="checkbox"/> Numbness/tingling in arms/hands	<input type="checkbox"/> Visual disturbances	<input type="checkbox"/> Recurrent colds/Flu
<input type="checkbox"/> Hearing disturbances	<input type="checkbox"/> Coldness in hands	<input type="checkbox"/> Low Energy/Fatigue
<input type="checkbox"/> Weakness in grip	<input type="checkbox"/> Thyroid conditions	<input type="checkbox"/> 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.

<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Recurrent Lung Infections/Bronchitis
<input type="checkbox"/> Heart Murmurs	<input type="checkbox"/> Asthma/Wheezing
<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Shortness Of Breath
<input type="checkbox"/> Heart Attacks/Angina	<input type="checkbox"/> 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*):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Neurological Problems	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Broken bones/fractures	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Hernia
<input type="checkbox"/> Pneumonia/Bronchitis	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Chicken Pox/Shingles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Blood Sugar Problems	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Lumbago
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Dyslexia	<input type="checkbox"/> Depression	<input type="checkbox"/> Learning Disorder
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> 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 for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: *do nothing - live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery.* There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

_____ Patient Name	_____ Signature	_____ Date
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_____ Witness Name	_____ Signature	_____ Date
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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 Health 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 your 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

