Complete Care Chiropractic Wellness Center

151 N. Sunrise Ave Suite #1413 Roseville, CA 95661 (916)749-1346

Personal and Family Health History

Name ____
Address ______________________________________
City ____________________ State ____ Zip ________
Phone: (H) _______________ (C) ________________
E-mail ____
❒ Exclude you from our monthly email list
Date of Birth ______________Age ______Gender M / F
Height: ____ft. ____in. Weight_________
Social Security # ______________________________

Date____
Referred By __________________________________
Occupation ___________________________________
Employer _____________________________________
Marital Status S M D W
Spouse's Name ________________________________
Person responsible for payment___________________
Insurance Contribution ❒Yes ❒N

Current Health Condition

Present Complaint, Reason for Your Visit Today?____

When did you first notice it?____

How did it happen?____

Pains are ❒ Sharp ❒ Dull ❒ Achy ❒ Throbbing ❒Other___________________ ❒ Constant ❒ Intermittent

Rate your pain 1-10, with 10 being the worst pain you can imagine. Today's pain________ Pain at best______ at Worst______

What aggravates your condition/pain? ____

What relieves your condition/pain? ____

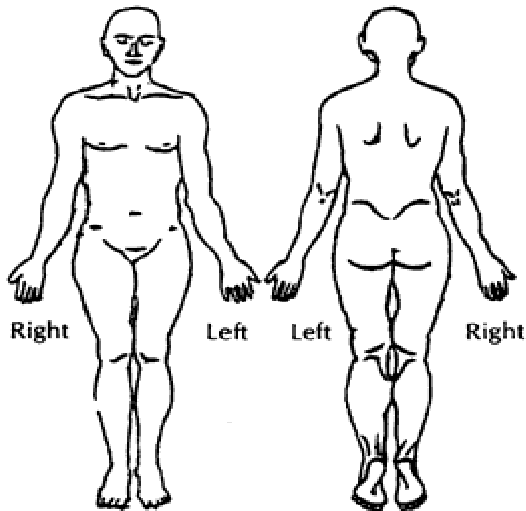
Is condition worse during certain times of the day? ____

Is this condition interfering with work? ______ Sleep? ______ Routine? ______ Other? ________________________

Is this condition getting ❒better ❒worse or ❒no change? Other Doctors seen for this condition?___________________

Any home remedies? ____

Are you now, or is there any possibility you might be pregnant ❒Yes ❒No



Please shade in the areas of complaint on left and mark it as follows:

P: Pain
N: Numbness
S: Stiffness
SP: Shooting Pain
W: Weakness

Accident History

❒Job ❒Auto ❒Other 1) ____ Date: ________________________

❒Job ❒Auto ❒Other 2) ____ Date: ________________________

❒Job ❒Auto ❒Other 3) ____ Date:________________________

Are you currently under the care of another Doctor or health care professional?______For What?_______________________________

Any over the counter/prescription drugs you take?____

Have You Had Surgery? ______For What?____ When?__________________

Side effects from drugs or surgery? ____

Have you broken any bones?❒ What?__________________ When?_______________

Any childhood injuries?❒ What?__________________ When?_______________

Do you have physical stress?❒ Occupational stress?❒ Mental stress?❒ Do you smoke?❒ Drink?❒

Other symptoms:

- ❒ Headaches
- ❒ Neck Pain
- ❒ Sleeping Problems
- ❒ Back Pain
- ❒ Asthma
- ❒ TMJ Problems
- ❒ Irritability
- ❒ Chest Pains
- ❒ Dizziness
- ❒ Concussion
- ❒ Neck Stiff
- ❒ Pins & Needles in Legs
- ❒ Pins & Needles in Arms
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Shortness of Breath
- ❒ Fatigue
- ❒ Depression
- ❒ Allergies
- ❒ Loss of Memory
- ❒ Osteoporosis
- ❒ Heart Trouble
- ❒ Fainting
- ❒ Hepatitis
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Diarrhea
- ❒ Cold Feet
- ❒ Cold Hands
- ❒ Acid reflux/Heartburn
- ❒ Constipation
- ❒ Loss of Balance
- ❒ High Blood pressure
- ❒ High Cholesterol
- ❒ Arthritis
- ❒ Diabetes
- ❒ Cancer
- ❒ Loss of bowl/bladder control
- ❒ Rheumatoid arthritis
- ❒ Other___________________

____ Signature

___________________ Date

Insurance Policy

Health Insurance: We are willing to work with almost all companies that will contribute to your chiropractic care. If you have insurance that covers chiropractic, full payment of services is expected until we verify your specific coverage. Once verified any payment credits you may have will be counted toward your future care. Your specific coverage may take up to 72 hours for verification. We will be happy to offer any assistance in this matter. Please remember, there are many different plans with many different levels of deductibles, Co-payments, Co-insurance and coverage restrictions.

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have
Name of Subscriber____________________________________
Patients Relationship to Subscriber ❒ Self ❒ Spouse ❒ Child ❒ Other
Birthday of subscriber_____________

LEGAL ASSIGNMENT OF BENEFITS AND HIPAA PRIVACY ACT

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or Employee health care benefits coverage with the provided copy, and hereby assign and convey directly to Complete Care Chiropractic/Dr. Adam Atkinson for insurance reimbursement, if any, otherwise payable to me for services rendered from such Doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

HIPAA

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent

I have read and I understand the above Insurance Policy and HIPAA form

______________________________________ __________________________

Signature of Insured/Pt or Guardian Date

Complete Care Chiropractic
Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Adam Atkinson and/or other licensed doctors of chiropractic who now or in the future work at Complete Care Chiropractic or any other office or clinic.

I have had an opportunity to discuss with Dr. Adam Atkinson and/or with other office or clinic personnel about the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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 I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also discussed or had an opportunity to discuss 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.

Patient Signature (or parent/guardian)__________________________ Date _________________

Patient Name (Print)___________________________

Witness Signature _________________________________ Date_____________

Doctor's Notes