Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME_____ DATE_____ EMAIL_____

ADDRESS_____ CITY_____ STATE _____ ZIP_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

DATE OF BIRTH_____ AGE____ M_____ F_____ SS #_____ MARITAL STATUS_____

OCCUPATION_____ SPOUSE NAME_____ # OF CHILDREN_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____ REFFERRED BY_____

Please check the appropriate box for any of the following symptoms which you now have or had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL REPORT

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C

GENERAL
- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Nervousness/Depression
- Neuralgia
- Sweats
- Tremors

MUSCLE & JOINT
- Arthritis
- Bursitis
- Hernia
- Low back pain
- Neck pain

PAIN OR NUMBNESS
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

GASTRO-INTESTINAL
- Belching or gas
- Colitis
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive appetite
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

EYES, EARS, NOSE & THROAT
- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

CARDIO-VASCULAR
- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY
- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN
- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

GENITO-UNRINARY
- Bed-wetting
- Blood in urine
- Frequent urination
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

WOMEN ONLY
- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge

Yes No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- Anemia
- Appendicitis
- Arteriosclerosis
- Arthritis
- Cancer
- Chorea
- Cold sores
- Diabetes
- Diphtheria
- Eczema
- Emphysema
- Epilepsy
- Fever blisters
- Goiter
- Gout
- Heart disease
- Influenza
- Lumbago
- Malaria
- Measles
- Miscarriage
- Mumps
- Pleurisy
- Pneumonia
- Polio
- Rheumatic fever
- Scarlet fever
- Stroke
- Tuberculosis
- Typhoid fever
- Ulcers
- Venereal disease
- Whooping cough
- Multiple sclerosis

Do you have Health and or Auto Insurance? Yes No If yes, what company_____

2211 CORINTH AVENUE SUITE 301 LOS ANGELES, CA 90064 PHONE 310-481-7160 FAX 310-478-8521
www.spinalandhealthcetner.com

PLEASE PRINT

What is your major complaint and how long have you had this condition? _____
_____
Have you had similar conditions in the past? □ Yes □ No
What activities aggravate your condition? _____
Is this condition progressively worse? □ Yes □ No □ Constant □ Comes and goes
Is this condition interfering with your: □ Work □ Sleep □ Daily routine □ Other_____
Other complains: _____
Is this an Auto Accident Case? □ Yes □ No
Have you been in an auto accident: □ Past year □ Past five years □ Over five years □ Never
Describe: _____
List previous diagnoses and treatments you have received for present condition _____
_____
List surgical operation(s) and year(s):_____
_____
Drugs you take: □ Nerve pills □ Pain killers □ Muscle relaxers □ "Pep" pills □ Tranquilizers □ Birth control pills
Others: _____
Dental Visits: □ Every six months □ Yearly □ Toothache or emergency only □ Complete dentures
Have you ever had any mental or emotional disorders? □ Yes □ No When? _____
Have others in your family had such disorders? □ Yes □ No When? _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health.)

NAME	RELATION	PAST &PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	**Yes**	**No**
Been knocked unconscious?	□	□
Used a cane, crutch, or other support?	□	□
Been treated for a spine or nerve disorder?	□	□
Had a fractured bone?	□	□
Been hospitalized for anything other than surgery?	□	□
DO YOU:		
Now take vitamins or minerals?	□	□
Have an allergy to any drug?	□	□

DATE OF LAST:	**Less than 6 month**	**Over 6 months**	**Never**
Spinal exam	□	□	□
Physical exam	□	□	□
Chest X- ray	□	□	□
Spinal X-ray	□	□	□
Dental X-ray	□	□	□
Blood test	□	□	□
Urine test	□	□	□

HABITS	**Heavy**	**Moderate**	**None**
Alcohol	□	□	□
Coffee	□	□	□
Drugs	□	□	□
Tobacco	□	□	□

IN CASE OF EMERGENCY: (Name of relative or friend not living in your home to contact):

NAME _____

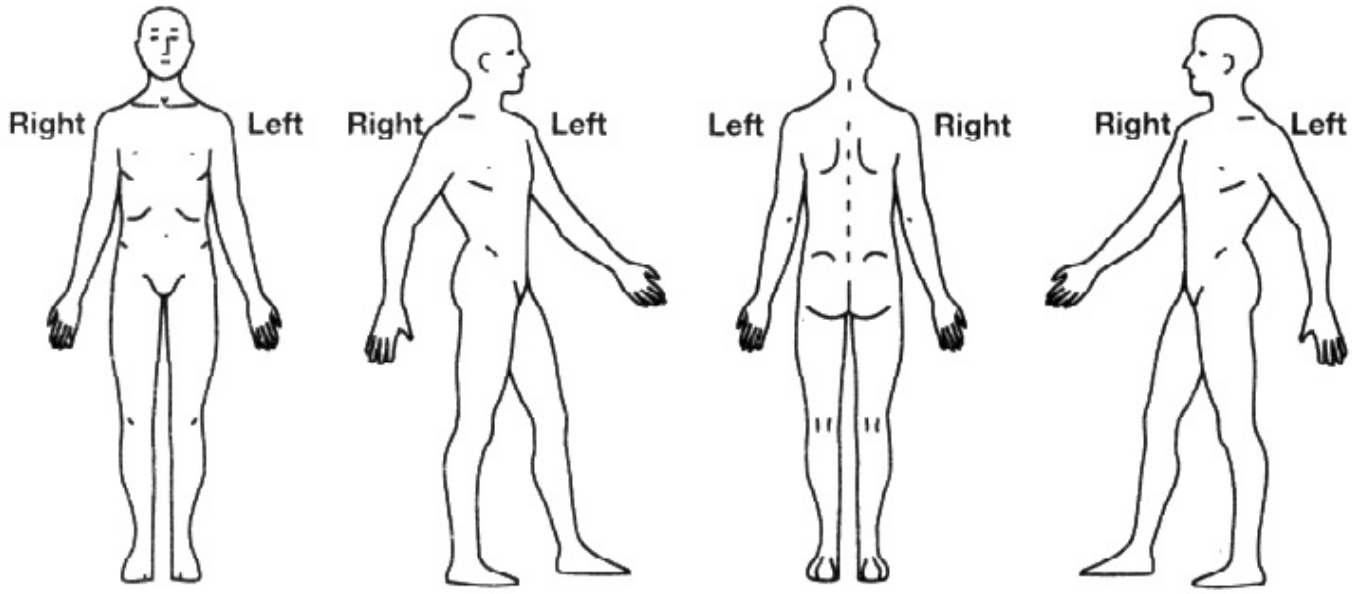
ADDRESS: _____ PHONE: _____

ANALOGUE PAIN SCALE

Name _____ Date: _____

Please **indicate** the appropriate **location of pain** and the symbol that best describes the discomfort you are presently experiencing.

Sharp and Stabbing – ++++
Dull and Achy – VVVV
Pins and Needles – 0000
Numbness – ////



Please mark the appropriate number to describe your present pain level with 1 being normal or no pain; and 10 being very severe pain.

C = CONSTANT
I = INTERMITTENT

Area of Pain	Normal	Mild Pain			Moderate Pain			Severe Pain				
Neck	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Middle Back	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Lower Back	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Hip(s) Lt Rt	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Shoulder(s) Lt Rt	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Arm(s) Lt Rt	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Leg(s) Lt Rt	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Headaches	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Other:	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Other:	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**
Other:	☐ 1	2	3	4	5	6	7	8	9	10	**C**	**I**

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 named below and/or other licensed doctors 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 or 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 adjustment and other procedures. I understand that the 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 on the doctor to be able to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and 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:

_____

Patient Name (Print)

_____

Patient Signature

_____

Date

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

_____

Print Name of Patient

_____

Print Name of Patient's Representative

_____

Signature of Patient's Representative

As: _____

Relationship or Authority of Patient's Representative

_____

Date Signed

To be completed by doctor or staff.

Name and address of clinic/office:

Spinal & Health Center of Santa Monica
2211 Corinth Avenue, Suite 301
Los Angeles, CA 90064
(310) 481-7160

Print name(s) of doctor(s) treating this patient:

Ira Schneider, D.C., C.C.S.P.

_____

_____

Witness to Patient's Signature: _____
(Date)

Translated By: _____
(Date)

The signed original is to be filed in patient's file and a copy is to be given to the patient.

HIPAA FORM - IRA SCHNEIDER, D.C., C.C.S.P.

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.

Ira Schneider, D.C., C.C.S.P. 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 (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Ira Schneider D.C., C.C.S.P."

"It is our policy to provide a substitute health care provider, authorized by Ira Schneider D.C., C.C.S.P. 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. (Example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Ira Schneider D.C., C.C.S.P. *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 medication, 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 a 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.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, we may call your home on the evening 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."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Ira Schneider D.C., C.C.S.P. sponsored events."

Change of Ownership

In the event that the practice of Ira Schneider D.C., C.C.S.P. is sold or merged with another organization, your health information/record will become the property of the new owner.

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 Ira Schneider, D.C., C.C.S.P. 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 Ira Schneider, D.C., C.C.S.P. amend your protected health information. Please be advised, however, that Ira Schneider, D.C., C.C.S.P. 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 Ira Schneider D.C., C.C.S.P.
- 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

Ira Schneider, D.C., C.C.S.P. 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, Ira Schneider, D.C., C.C.S.P. is required by law to comply with this Notice.

Ira Schneider, D.C., C.C.S.P. 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 Ira Schneider D.C., C.C.S.P. by calling this office at (310) 481-7160. If Ira Schneider D.C., C.C.S.P. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

COMPLAINTS

Complaints about your privacy rights, or how Ira Schneider, D.C., C.C.S.P. has handled your health information should be directed to Ira Schneider, D.C., C.C.S.P. by calling this office at (310) 481-7160. If Ira Schneider D.C., C.C.S.P. is not available, you may make 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 _____/_____/_____

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

By way of my signature, I provide Ira Schneider D.C., C.C.S.P. with my authorization and consent to use and disclose 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