Health Connection Chiropractic

www.healthconnectchiro.com

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San Jose, Ca 95125
408-624-7543

550 Sunol Blvd Suite 5
Pleasanton, Ca 94566

CONFIDENTIAL PATIENT INFORMATION:

Name_____Social Security #_____ Date of Birth _____
Age _____ Sex: M F Marital Status (circle one) M S D W Number of Children _____
Address:_____City/State_____ Zip_____
Home Number_____Cell Number_____Carrier for Text reminders _____
E-Mail_____
Occupation_____
Work Address _____City/State_____Zip_____
Employer _____
Who may we thank for referring you to our office? _____
Have you ever had chiropractic before? __Yes __ No Date of Last Treatment _____
Is your condition or injury related to: Employment _____ Auto Accident _____
If yes: Date of Injury: _____Location _____

INSURANCE INFORMATION:

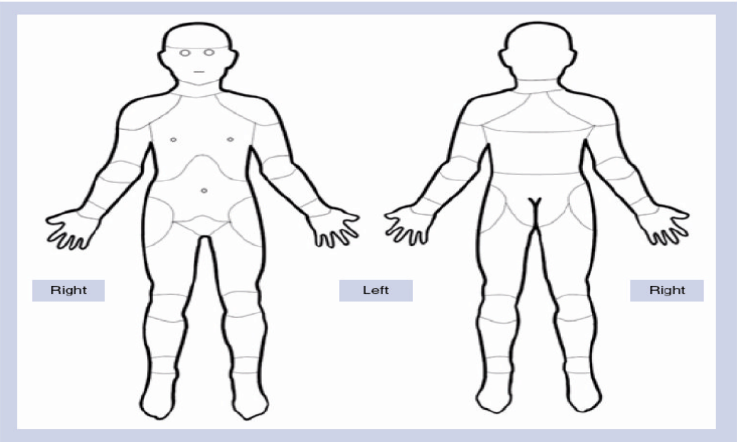
Primary Insurance Company _____
Group Number _____
Member ID_____
Address _____ Phone_____
Verification is not at guarantee of benefits

Emergency Contact Name: _____Relationship:_____ Phone #_____

I authorize Health Connection Chiropractic to render necessary services to me and I am responsible for all charges incurred. All charges are due when services are rendered, unless other arrangements are made.

Method of payment:
Cash__ Check__ Apple Pay__ Venmo__ FSA__ HSA___ Credit Card___ (3% transaction fee)
To Continue to offer complimentary and discounted services to those in financial need a processing fee is added to all credit card transactions.

Signature _____ Date _____
Guardian or Spouse's Authorizing Care_____



Height: _____ Weight: _____

Mark where you feel pain on the diagram above:

List and describe your chief complaint based on severity and how it began:

1)_____ Describe: _____ Previous Treatment: _____
What worsens your symptoms and what provides relief?_____
Date Symptom began:_____ Rate your pain (0 no pain -10 unbearable pain) _____
Frequency:___0-25%___ 26-50% ___ 51-75% ___ 76-100%
Has this pain interfered with your daily activities or chores? Rate (0 no interference -10) _____

2)_____ Describe: _____ Previous Treatment: _____
What worsens your symptoms and what provides relief?_____
Date Symptom began:_____ Rate your pain (0 no pain -10 unbearable pain) _____
Frequency:___0-25%___ 26-50% ___ 51-75% ___ 76-100%
Has this pain interfered with your daily activities or chores? Rate (0 no interference -10) _____

3)_____ Describe: _____ Previous Treatment: _____
What worsens your symptoms and what provides relief?_____
Date Symptom began:_____ Rate your pain (0 no pain -10 unbearable pain) _____
Frequency:___0-25%___ 26-50% ___ 51-75% ___ 76-100%
Has this pain interfered with your daily activities or chores? Rate (0 no interference -10) _____

List health professionals you have consulted for complaints listed above. _____
Have you had spinal X-rays or MRI taken of areas of complaints? _____
Have you experienced major injuries such as auto accidents, sport injury/falls?_____

Medications:
List any medications you are currently taking and purpose:
1)_____ 4)_____
2)_____ 5)_____
3)_____ 6)_____

Are you interested in reducing your need for medication and improving systemic health with holistic modalities? ____ yes ____ no

Surgical History:
List any medical previous or upcoming surgeries and date: (spinal fusion, hip/knee replacements, c-secition delivery, laminectomy, etc.)
1)_____Date:_____
2)_____Date:_____
3)_____Date:_____

Supplements:
List Current Supplementation
1)_____ 3)_____
2)_____ 4)_____

Number of Children: _____ Ages: _____ _____ _____ _____ _____

We promote whole family wellness. Would you be interested in a functional chiropractic assessment for better health? ___ Yes ___ No

Habits:
Do you exercise? ___ Yes ___ No How many hours do you sit a day? _____
Rate your sleep quality check all that apply:
__ Wake from sleeping __ Snoring __ Sleep Apnea
__ Difficulty falling asleep __ Restless Legs __ Nightmares/Terrors

Diet:
List any known food allergies: _____

Do you regularly consume: (check all that apply)

	Light	Moderate	Heavy
Alcohol			
Wheat/ Gluten			
Tobacco/Vapes			
Sugary Foods			
Salty Foods			
Artificial Sweeteners			
Soft Drinks/ Sport Drinks/ Caffeine Drinks			

The body can become burdened with exotoxins and endotoxins increasing pain and inflammation. Would you be interested in reducing inflammation and promote faster healing with supplementation/ detoxification? __ Yes __ Not at this time

Family Medical History:
Please mark/ list (and specify if necessary) any condition that you or a member of your family has experienced.

	Self	Parent	Sibling	Grandparent	Aunt/Uncle
Anemia					
Arthritis/Type					
Artery Dissection					
Cancer/Type					
Diabetes					
Depression/Anxiety					
Heart Disease/ HBP					
High Cholesterol					
Fractures/Broken Bones					
Thyroid Disorder					
Stroke/Difficulty Talking or swallowing					
Double Vision/ Sudden Falling/Fainting					
Other:					

Genetic Background: __ Caucasion __ Hispanic __African American __ Native American
__ Mediterranean __ Northern European __ Asian __ Other: _____

NOTES:

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.

Health Connection Chiropractic 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. Payment We may disclose your health information to your insurance provider for the purpose of payment or health care operations. 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. 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. 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. Promotional Use: Health Connection Chiropractic may use any pictures and or recordings for promotional uses. Your Health Information Rights 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.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Health Connection Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient Signature or Guardian _____ Date _____

Informed Consent

Chiropractic care like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic manipulation. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, in rare instances fractures and stroke. "Serious complications are infrequent, with reported incidents between one per 100,000 and one per 200,000,000 manipulations" South Med J 2007: 100(2):201-3
Initial By way of my signature, I acknowledge the above information and approve treatment.

Cancellation Policy: I understand that I need to give 24 hours notice for a cancellation or I will charged a minimum of **$40** and up to **$85** for the adjustment fee for the missed appointment. Emergencies and exceptions will be determined by practitioner. After **one** cancellation or no show a fee will be charged for subsequent missed appointments.

Patient Signature or Guardian _____Date_____