

Name: _____ Date: _____

Address: _____

SS#: _____ Date of Birth: _____ Medicare: ____ Yes ____ No

Email: _____ Occupation: _____

☐ Please add me to your email list for appointment reminders, health info., and news.

Male: ____ Female: ____ Marital Status: _____ # of Pregnancies _____ Children: _____

Spouse's Name: _____

Person to Contact in Case of Emergency: _____ # _____

How did you hear about us? _____

Do you have any open cases in these categories:

____ Motor Vehicle Accident/Personal Injury ____ Work Comp Injury

Please describe: _____

List the 5 main reasons for your
appointment today (in order of importance):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

- ☐ Surgeries
- ☐ Accidents/Injuries
- ☐ Hospitalizations

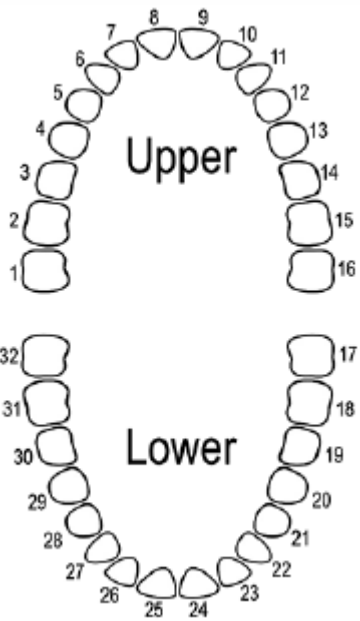
Dates:	Descriptions:
_____	_____
_____	_____
_____	_____

Medications, Vitamins, Herbs:

Dental History:

Please mark any current or past areas with:
cavities, fillings, implants, crowns, root canal,
or other dental surgeries.

Any additional information you would like to share:



- X** –Current Cavity
- XX**-Filled
- IMP**-Implant
- C**-Crown
- RC**-Root canal

Orthodontics:

____ Current ____ Past

PATIENT: _____

DATE: _____

PATIENT HISTORY

1. What is your **main complaint**? _____

2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

None	Slight			Mild	Moderate			Severe	
1	2	3	4	5	6	7	8	9	10

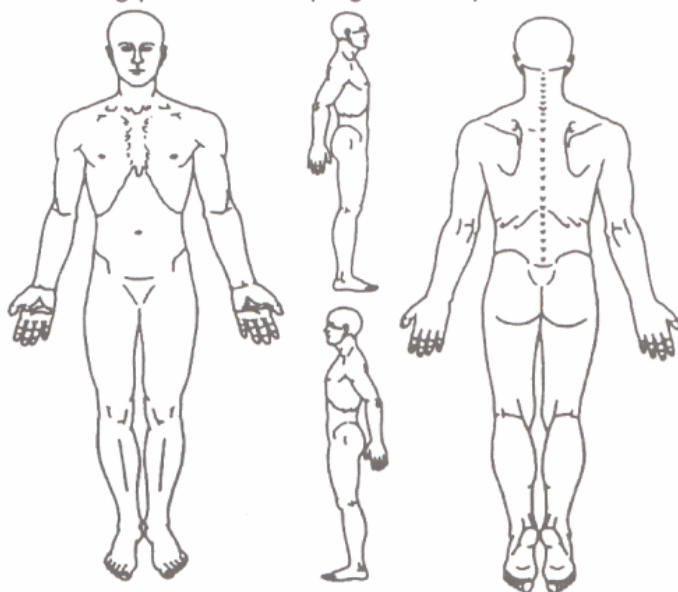
3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

Occasional				Intermittent				Frequent		Constant		%
0	10	20	30	40	50	60	70	80	90	100		

4. How **long** have you been experiencing your **main complaint**? _____

5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care _____

lifting _____

reading _____

concentrating _____

work _____

driving _____

sleeping _____

recreation _____

walking _____

sitting _____

standing _____

social life _____

6. When do you notice it most? ☐ AM ☐ PM

How long does it last? _____ Mins _____ Hrs

7. What makes it feel better? _____

8. What makes it feel worse? _____

9. Have you ever had this problem in the past? ☐ Yes ☐ No

10. I have ☐ been hospitalized ☐ been treated by another chiropractor
☐ been treated by another specialty provider ☐ never received care for this problem.

11. Have you lost time from work because of it? ☐ Yes ☐ No

Dates? _____ to _____

12. Are you Pregnant? ☐ Yes ☐ No Date Due _____

13. What was the first day of your last menstrual cycle? _____

14. Number of pregnancies? _____ Miscarriages? _____

Signature: _____

Date: ____/____/____

Health History

Check any of the following conditions You have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety/depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Headaches-migraine | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer type _____ | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus infection |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Vertigo/dizziness |

Females: Are you pregnant? ____ Yes ____ No

Check any of the following conditions that a Family Member has had:

- ☐ Cancer
- ☐ Rheumatoid arthritis
- ☐ Diabetes
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Epilepsy
- ☐ Chronic back problems
- ☐ Chronic headaches
- ☐ Lupus
- ☐ Other _____

Stressors: please circle

Smoking Packs/Day _____

Alcohol Drinks/Week _____

Coffee/Caffeine Drinks Cups/Day _____

Stress level None Moderate Heavy Cause: _____

Exercise (please circle): None Moderate Heavy

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition.

Name: _____ Date: _____

Signature: _____ Date: _____

Informed Consent

By signing this form, you are consenting to an examination by Dr. Robles, D.C. Dr. Robles employs standard chiropractic examination methods including the following:

Observations: General assessment/appraisal in all positions.

Inspection: Viewing/looking at our body parts. Visualization including general body viewing in standard positions: front, back, and sides. All symptomatic (painful) body parts may be viewed.

Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.

Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity of tissues, integrity, and orthopedic/neurological testing; these are standard tests to assess your neuromusculoskeletal systems.

NOTE: You do not have to submit to any examination procedure. I ask you to comply to the best of your ability and report changes in your pain. All procedures are accomplished to your tolerance. Please let me know if you are uncomfortable with any examination or treatment procedure.

I, _____ understand the above agreement
(print name)

and agree to submit to the procedures and accept the risks and consequences of their application.

Signature: _____ Date: _____

Fee Schedule

Initial Appointment \$200.00

(For new patients or patients with a gap in care of 1 year or greater)

Follow up Appointments Adults (ages 12+) \$65

Children \$55

Re-Exam (All ages) \$150

(gaps in care 3 months – 1 year)

(big health changes, life events, or injury)

Lab Analysis & Report of Findings Appointment \$135

Labs Varied based on lab needed

Nutrition, Herbs, Homeopathics Varied based on product needed

Payment is due at time of service. A Superbill (receipt with billing codes) can be provided upon request but does not guarantee your insurance will provide reimbursement.

Appointments canceled, missed, or rescheduled less than 24 hours in advance will be charged full price.

Print name: _____ Date: _____

Signature: _____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dr. Robles, D.C. is required by law to maintain the privacy and confidentiality of your protected health information and provide our patients with notices of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your health information: Treatment:

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, and healthcare operations. (Example)

1. If it becomes necessary to seek consultation regarding your condition from other health care providers associated with Dr. Robles
2. Health professionals and/or staff working with Dr. Robles to provide you with care.
3. If Dr. Robles has an emergency absence and you accept a recommendation from Dr. Robles to a substitute healthcare provider.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health operations. (Example)

1. Upon request, Dr. Robles will provide an itemized billing statement. This statement contains medical information including diagnosis, date of injury or condition, and codes which describe the health care services you received.
2. When you submit to your insurance for reimbursement, your insurance company may ask for copies of your health records.

Emergencies:

We may disclose your health information as necessary in the event of an emergency.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to preventing injury or disability, reporting child or elder abuse or neglect, reporting domestic violence, 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. If the California Chiropractic Board of Examiners demands access to our patient records, we are required to provide access.

Law Enforcement

We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing persons, complying with a court order or subpoena or other law enforcement purposes.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious or imminent threat to the health or safety of a particular person or the general public.

Marketing

We may contact you for marketing purposes, or fundraising purposes, as describe below:

As a courtesy, Dr. Robles will occasionally call to check in with patients whom she has not seen for a time. We may also contact you for an event sponsored by us. If you are not at home, we will leave message on your answering machine or with the person answering the phone. No personal health information will be disclosed during the recording or message other than that the person calling is, or is working for, Dr. Robles along with a request to call our office.

Change of Ownership

In the event that Dr. Robles sells or merges her business 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 Dr. Robles is not required to agree to the restriction that you requested.

You have the right to have your health information received and communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your written request. You understand and accept that the method you request may not be HIPAA (Health Insurance Portability and Accountability Act) and/or GDPR (General Data Protection Regulation) compliant. This means that you accept responsibility for the fact that you are requesting that your personal health information be sent in a way that may not ensure your privacy.

You have the right to inspect and copy your health information.

You have the right to request that Dr. Robles amend your protected health information. Please be advised, however, that Dr. Robles is not required to agree to amend your protected health information. If your request to amend your health information is denied, you will be provided with an explanation of your denial reason(s).

You have the right to receive an accounting of disclosures of your protected health information made by Dr. Robles.

You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Dr. Robles 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 the information that it maintains. Until such amendment is made, Dr. Robles is required by law to comply with this Notice.

Dr. Robles is required by law to maintain the privacy of your health information and 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 our office by calling: 916-755-3522.

Complaints

Complaints about your Privacy rights, or how Dr. Robles has handled your health information should be directed to Dr. Robles by calling the office at: 916-755-3522. If you are not satisfied with the manner in which our office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights

Room 509F HHH building

Washington, DC 20201

This notice is effective as of 4/21/19.

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

Printed name: _____

Date: _____

Signature: _____

Date: _____

Authorized Facility Signature: _____ Date: _____