Momentum
Health & Wellness Institute

895 E. Yorba Linda Blvd, Suite 103, Placentia, CA 92870 PH: 657-275-9092 | Text: 714-451-6043

CONFIDENTIAL PATIENT INFORMATION

These forms are legal documents and are necessary to bill insurance and are a part of your medical chart. They must be completed in detail so please take your time and ask for assistance if you need help.

GENERAL INFORMATION

Date: _____

First Name_____ **Last Name**_____

Address_____**City**_____**State**____**Zip**_____

Home Phone_____**Work Phone**_____**Cell Phone**_____

Gender: Male____ **Female**____ **Marital Status: S M D W Number of Children**_____

Date of Birth_____**Age**_____ **Email Address** _____

Driver License #_____**Social Security #**_____

Employer Name_____**Occupation**_____

Address of Employer_____**City**_____**State**____**Zip**_____

Name of spouse_____**Spouse's Employer**_____

Name of nearest relative not living with you_____

Address_____ **Phone**_____

Is the condition you are here for the result of a work related injury? ☐ YES ☐ NO

(If YES, have you reported it to your supervisor?) ☐ YES ☐ NO

Is the condition you are here for the result of an automobile collision? ☐ YES ☐ NO

How do you intend to pay for today's visit?_____

Do you have health insurance? ☐ YES ☐ NO Insurance Company_____

(If YES, please provide the receptionist with a copy of your insurance card.)

Name of policy holder_____

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

Who referred you to our office?

☐ A friend/relative/co-worker/other referred me. Name of person_____

☐ Website/Internet Listing. Circle one: Google Yelp Facebook Other_____

☐ My work provided a health fair or health talk

☐ Other. Please describe source:_____

Patient Agreement:

ASSIGNMENT AND RELEASE

I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any Insurance company which may become obligated to pay me any sums. The Patient(s) grant(s) to the Provider a Limited Power of Attorney to receive funds, negotiate any drafts or checks and execute any documents related to payment for services rendered to me.

_____ _____

Patient/Parent/or Guardian Signature Date

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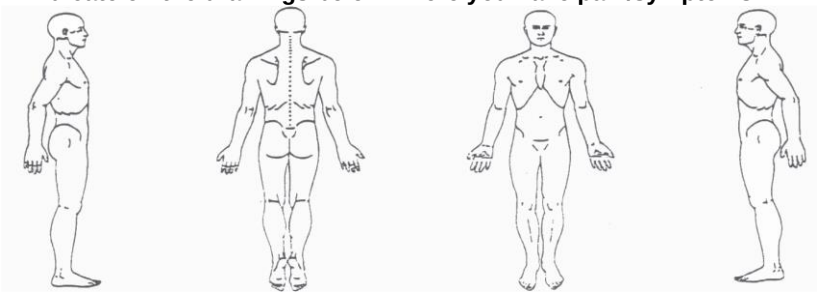
Patient Symptoms and History

Patient Name: _____ **Date:** _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Neither

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Shooting □ Shooting with motion
□ Dull □ Stiff □ Stabbing with motion
□ Diffuse □ Numb □ Electric-like with motion
□ Achy □ Tingly □ Other: _____
□ Burning □ Sharp with motion

5. How are your symptoms changing with time? □ Getting worse □ Not changing □ Getting better

6. Using a scale from 0 – 10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with you social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER Physician □ Orthopedist □ Other: _____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What makes your problem better?

_____

15. What concerns you the most about you problem; what does it prevent you from doing?

_____

16. What is your: Height _____ **Weight** _____ **Age** _____ **Occupation** _____

17. How would you rate your overall Heath? □ Excellent □ Very Good □ Good □ Fair □ Poor

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18. What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Other: _____
□	□ Jaw Pain	□	□ Abdominal Pain		
□	□ Joint Pain/Stiffness	□	□ Ulcer		
□	□ Arthritis	□	□ Hepatitis		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue	**For Females Only**	
□	□ Tumor	□	□ Muscular Incoordination	□	□ Birth Control Pills
□	□ Asthma	□	□ Visual Disturbances	□	□ Hormonal Replacement
□	□ Chronic Sinusitis	□	□ Dizziness	□	□ Pregnancy

21. List all prescription medications you are currently taking:

_____

22. List all supplements, vitamins and herbs you are currently taking:

_____

23. List all surgical procedures you have had:

_____

24. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer Work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half the day	□ A little of the day

25. What activities do you do outside of work?

_____

26. Have you ever been hospitalized? □ No □ Yes If yes, why _____

27. Have you seen a Chiropractor before? □ No □ Yes If yes, how long? _____ and Why _____ What were the results? □ Good □ Mixed □ Poor

28. Have you had significant past trauma? □ No □ Yes

29. Anything else pertinent to your visit today? _____

Patient Signature _____ **Date** _____

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HIPAA NOTICE OF 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.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Open Therapy Policy

This office utilizes an "open-therapy" environment for on-going patient care. Patients are in sight of one another during exercise and/or modality therapy service and some on-going routine details of care are discussed within earshot of other patients and staff. This is NOT the environment used for taking the initial patient history and examination or presenting reports of findings, these procedures are held in a private confidential setting. If you choose to not receive therapy in this format, please notify the staff or doctor and other arrangements will be made for you.

Appointment Reminders

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Family/Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.
- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization

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You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions

You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

You Have a Right to

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

PRACTICE'S REQUIREMENTS

The Practice is required by federal law to: maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI, and abide by the terms of this Privacy Notice. The Practice reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains; will distribute any revised Privacy Notice to you prior to implementation; and, will not retaliate against you for filing a complaint.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (Printed): _____

Patient Signature:_____ Date: _____

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Informed Consent

Some risk is assumed in all treatment modalities, including chiropractic adjustments. Manipulation or adjustment of the human frame carries small risk of injury to weakened or hidden pathology of the vertebral artery in the neck causing death or stroke in reported 1 per 400,000 cases to 1 per 10 million cases. Every effort is made to screen for this and use methods with the lowest risk. Your doctor of chiropractic is the highest licensed professional for specific and safe adjustment of the human frame.

Other complications may rarely include; strain, sprain, dislocation, fracture, disk aggravation, physiotherapy burns, muscle soreness, aches, or other injury. Please ask your doctor of chiropractic if you have any questions.

Subluxation is a misalignment and/or "stuck" joint or tissue, which is found to cause nerve impingement. This interferes with any organ, tissue, or blood vessel supplied by that nerve. Your doctor of chiropractic is trained to look for and find these subluxations, and to correct them with an adjustment. Please do not "pop" or "crack" your joints using a thrust of any kind, nor have an unlicensed person do it for you. Not only can you be hurt, you most likely will not achieve the correction you are looking for. Proper stretching can be very beneficial, and painless popping sounds may be heard and are normal, as long as no forceful thrust or impulse is applied.

After a specific adjustment some people experience the effects of renewed nerve flow and circulation to impinged areas that were restricted by their subluxation. These historically have been changes in; sweating patterns, increased respiratory capacity, faster bowel transit time, increased bowel movement frequency, shift in center of balance perception, sleep pattern changes, shoe fit and clothing measurements, differences in walking (gait), and various organ function changes. These subside quickly as the tissue adjusts itself to the restored nerve flow, but may be temporarily necessary in order for the tissue cells to excrete stored wastes.

Patient Name:_____ Date:_____

Patient Signature:_____

IF PATIENT IS A MINOR

I understand the informed consent and hereby consent to treatment of my minor child

Named_____ Child's date of birth:_____

Parent or guardian Name: _____

Parent or guardian signature: _____Date:_____