

New Patient Health History Form

Patient Data

First Name _____ Last Name _____ Email _____

*Your email will NOT be shared with any 3rd parties, and is used only for occasional office announcements and promotions

Mailing Address

Address _____ City _____ State _____ Zip _____ Birth Date _____

Age _____ Male _____ Female _____ Cell Phone _____ Home Phone _____

SS# _____ Occupation _____ Employer _____

Number of children _____ Marital Status _____ Spouse's Name _____ Referred By _____

Emergency Contact _____ Relationship: _____ Phone _____

Current Complaints

Nature of Injury: _____ Auto _____ Work _____ Other. Please describe your symptoms: _____

Is it possible that your injury could have been caused by an auto accident within the last 1-2 years? _____ YES _____ NO

Have you retained an attorney? _____ YES _____ NO

Date of Injury _____ Date symptoms appeared _____ Have you had the condition before? _____ YES _____ NO

If yes, when did you have the condition? _____ Have you ever been under chiropractic care? Y/N

List other practitioners seen for this injury/condition _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? _____ YES _____ NO Name of company _____

Subscriber's Name _____ DOB _____ Policy ID# _____ Employer _____

Do you have a secondary health insurance? _____ YES _____ NO If yes - Insurance company name _____

Subscriber Name _____ DOB _____ Policy ID# _____ Employer _____

Signatures

I (_____) understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ☐ YES ☐ NO

If yes, please describe:

Date of last physical exam _____ Date of last blood work _____

Is there a chance you are pregnant? ☐ YES ☐ NO

Have you had x-rays taken? ☐ YES ☐ NO If yes, where? _____

Please **list all medications** you are taking and for what conditions:

What vitamins, minerals, or herbs do you currently take? _____

Have you ever:

Been in an auto accident? ☐ YES ☐ NO Explain: _____

Broken bones? ☐ YES ☐ NO Explain: _____

Been hospitalized? ☐ YES ☐ NO Explain: _____

Had any surgeries? ☐ YES ☐ NO Explain: _____

Had any sprains/strains? ☐ YES ☐ NO Explain: _____

Had any head injuries? ☐ YES ☐ NO Explain: _____

Family History

Please list any past or present health conditions of your parents (example: heart disease, cancer, diabetes, arthritis, etc.)

Allergens

Please list any allergies and your reaction upon exposure:

Have you ever suffered from:

☐ Anemia
☐ Arteriosclerosis
☐ Arthritis
☐ Bronchitis
☐ Cancer
☐ Chest pain/conditions
☐ Constipation
☐ Depression
☐ Diabetes
☐ Digestion problems
☐ Dizziness
☐ Ears ringing
☐ Excessive menstruation
☐ Eye pain difficulties
☐ Fatigue
☐ Frequent urination
☐ Headache
☐ High blood pressure
☐ Irregular heart beat
☐ Irregular menstrual cycle

☐ Kidney infection
☐ Kidney stones
☐ Loss of memory
☐ Loss of balance
☐ Loss of smell
☐ Loss of taste
☐ Muscle cramps
☐ Neck pain
☐ Neck stiffness
☐ Nervousness/Anxiety
☐ Pacemaker
☐ Poor posture
☐ Prostate trouble
☐ Sciatica
☐ Shortness of breath
☐ Spinal curvatures
☐ STD
☐ Stroke
☐ Swelling of ankles
☐ Swollen joints
☐ Thyroid condition
☐ Ulcers

Habits

Check what best applies to you and answer the following questions:

Alcohol ☐ None ☐ Casual ☐ Moderate ☐ Heavy

Caffeine ☐ None ☐ Less than 3 drinks per day ☐ 3-6 per day ☐ More than 6 per day

Smoking ☐ Never ☐ Currently every day ☐ Currently some days ☐ Former

Drug Use ☐ None ☐ Recreational ☐ Addiction

Exercise ☐ None ☐ Rarely ☐ 2-4 times per week ☐ Daily

How many ounces/cups of water do you drink per day?

How would you describe your appetite?

What are your sleeping habits?



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of Chiropractic, medical doctors, osteopathic physicians and physical therapists who use manual therapy techniques such as manipulation of the spine and or extremities are required to advise patients that, although extremely rare, there may be some risks associated with such treatment.

In particular on rare occasions, patients have experienced rib fractures, muscular strains, or ligamentous sprains following spinal adjustments. Some type of spinal adjustments of the neck leading to or contributing to complications including stroke. This has been the subject of tremendous disagreement within and out of the profession, with one prominent authority stating that at most there is a one in one million chance of a stroke occurring as a result of a chiropractic adjustment of the neck. We employ tests in our examination which are designed to identify such susceptibility to that kind of injury. There have also been rare reported cases of disc injuries in the time following manipulation of the spine, although no scientific study has ever demonstrated with certainty that disc injuries have been specifically resulted by such treatment.

Chiropractic treatment including manipulation has been the subject of governmental reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches, nerve pain, and many other conditions. Chiropractic care contributes to your overall well being. The risks of injury or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same conditions.

Ancillary treatments recommended: Ice, Moist Heat Packs, Stretching/Strengthening Exercises, Massage Therapy, Electrical Muscle Stimulation (EMS), and Cold Laser Therapy.

Risks involved with the recommended ancillary treatments: Ice, Heat and Electrical Muscle Stimulations (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching/Strengthening Exercises and Decompression Spinal Traction can cause temporary post-treatment soreness or reflex muscle spasms. This list is not all inclusive.

PLEASE READ BEFORE SIGNING

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time based on the facts then known, is in my best interests. I understand that the results are not guaranteed. I acknowledge that I have discussed or have had the opportunity to discuss with my chiropractor the nature and purpose of the chiropractic treatment which I am about to receive (including chiropractic manipulation) as well as the contents of this consent form. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including chiropractic manipulation.

Name _____

Date _____

Signature (Patient/Guardian) _____

Witness Signature _____

Dr. Anthony Becerra, D.C.
25186 Hancock Avenue, Suite 100, Murrieta, CA 92562
(951) 461-4617



ASSIGNMENT OF PROCEEDS

(Agreement)

I understand that I remain personally responsible for the total amounts due to **Pure Chiropractic** for their services. This agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Pure Chiropractic** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **Pure Chiropractic** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

Name (print) _____ Date _____

Patient Signature _____

Name of Custodial Parent or Legal Guardian (print) _____

Parent/Guardian's Signature _____ Date _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specified adjustments of the spine.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interferes with the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. If during the course of a chiropractic spinal examination, however, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. We may use other procedures, however, to help your body hold the adjustments.

I, _____, have read and fully understand the above statements.

I therefore accept chiropractic care on this basis.

Patient Signature _____ Date _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I, _____ am not pregnant and Pure Chiropractic have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. **Date of last menstrual period** _____

Patient Signature _____ Date _____

CONSENT TO EVALUATE AND ADJUST A MINOR

I, _____ (print name), being the parent or legal guardian of _____ (print child's name), have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Patient/Guardian Signature _____ Date _____

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APPOINTMENT CANCELLATION & NO SHOW POLICY

APPOINTMENTS

At Pure Chiropractic there is nothing more important than our commitment to your health. We take this responsibility very seriously. Please arrive on time for your appointments. Our doctors do their best to stay on schedule and we all respect your time. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and, when it is missed, that time cannot be used to treat another patient.

CANCELLATION / NO SHOW POLICY

If you need to cancel or reschedule your appointment we kindly ask that you give us a 24-hour notice. This policy allows other patients access to care when needed and to avoid the expense to our office due to late cancellations and no shows. We take your time very seriously and are committed to providing you with the highest level of care.

If you call with less than 24-hour notice or if you do not call at all, we reserve the right to bill you for the time we reserved especially for you. The Cancellation / No Show Fee is \$25 for chiropractic treatment visits and \$50 for chiropractic review of findings and new patient visits. We understand there are unpredictable situations that cannot be helped so please contact us to share your unique situation.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation / No Show Policy of Pure Chiropractic and I agree to be bound by its terms.

Patient's Signature

Date

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NOTICE OF PRIVACY (HIPAA)

I, _____ acknowledge being informed of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I am fully aware and fully understand that there is a copy located in the patient waiting room for my convenience. I fully understand that HIPAA is a notice describing:

- Pure Chiropractic's commitment to my privacy
- How Pure Chiropractic may use and disclose my identifiable health information
- My rights regarding my individually identifiable health information

I furthermore understand that the terms of the HIPAA notice apply to all records containing my individually identifiable health information that is created or retained by Anthony Becerra, D.C. at Pure Chiropractic. Pure Chiropractic reserves the right to revise or amend the Notice of Privacy Practices (HIPAA). Any revision or amendments to the HIPAA notice will be effective for all my records that Anthony Becerra, D.C. or Pure Chiropractic may create or maintain in the future. Pure Chiropractic will post a copy of their most current HIPAA notice in a visible location in the patient waiting room at all times. I am also fully aware that I may request a copy of Pure Chiropractic's most current HIPAA notice at any time.

Print Patient's Full Name

Patient Signature

Date

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