PETERS CHIROPRACTIC CLINIC

Helping You Reach Optimal Health

**CHIROPRACTIC CASE HISTORY**

**Reason for your visit (Circle): Chiropractic Nutrition Orthotics**

Date _____ Name_____ Sex M__ F__ Marital Status: S M D (other)

Address_____ City_____ State_____Zip_____

H.Phone (____)_____ Cell (____)_____ Email_____

Date of Birth_____Age_____ Occupation_____ Employer_____

Have you ever received Chiropractic Care? Yes No If yes when?_____

In Case of Emergency: (____) _____ Name:_____ Relationship_____

**1. Primary reasons for seeking chiropractic care:**

Reason for Visit: _____ Location of Complaint: _____

Complaint began when and how: _____

The above condition(s) is/are due to Auto Accident: YES NO **or** Work Related Injury: YES NO

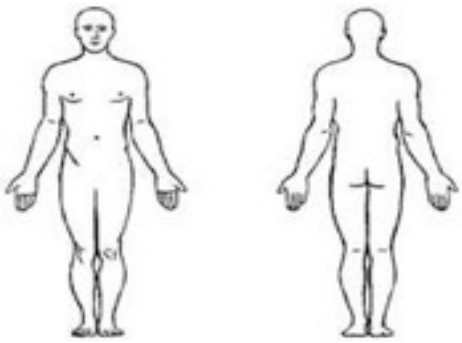
**Please circle the Quality of the complaints/pain**: deep persistent sharp shooting burning throbbing deep nagging

Does this complaint/pain radiate or travel (shoot) to any areas of your body? YES NO Where?_____

Do you have any numbness/tingling in your body? YES NO Where?_____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

**Shade or mark on the figure your area of pain**



a). **How frequent is complaint present, how long does it last?**
_____

b). **Does anything aggravate the complaint?**
_____

c). **Does anything make the complaint better?**
_____

d). **Do you have flat-feet, or pain in your feet?** _____

**2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint (list any OTC medications here)** :

_____

_____

_____

### 3. Past Health History:

A. Previous injury or trauma_____

B. Previous/current illnesses: (i,e., diabetes, high blood pressure, cholesterol)_____

C. Allergies: _____

D. Medications/Vitamins You Are Currently Taking:

| Medication(s) / Vitamin(s) : | Reason for taking |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

E. Surgeries You Have Had (Females, list pregnancies and outcomes here):

| Date | Type of Surgery |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**FEMALES ONLY:**

What was the date of the beginning of your last menstrual period? _____ **Are you Pregnant now? YES NO**

### 4. Family Health History:

Associated health problems of relatives (circle):

Mother: Cancer Heart Diabetes Other _____ Father: Cancer Heart Diabetes Other _____

Sibling: Cancer Heart Diabetes Other _____ Sibling: Cancer Heart Diabetes Other _____

### 5. Social and Occupational History:

Level of Education: ( ) High School ( ) Some College ( ) College Graduate ( ) Post Graduate Studies

Job description: _____

Work schedule:_____

Lifestyle/Exercise Routine (including tobacco and/or drug use, diet): _____

_____

**COMPREHENSIVE MEDICAL HISTORY:** I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature _____Date_____

## Peters Chiropractic Clinic
## Informed Consent to Chiropractic Adjustments and Care

**RCW 18.25.005 "Chiropractic" defined**

(1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care of treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.

(3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which will- include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedure consistent with this chapter.

**RCW 18.25.006 Definitions**

(5) "Vertebral Subluxation Complex" means a functional defect or alteration of the biomechanical physiological dynamics in a joint that may cause neuronal disturbances, with or without displacement detectable by x-ray. The effects of the vertebral subluxation complex may include, but are not limited to, any of the following: Fixation, hypo mobility, per articular muscle spasm, edema, or inflammation.

(9) "Chiropractic Adjustment" means chiropractic care of a vertebral subluxation complex, articular dysfunction, or musculoskeletal disorder. Such care includes manual or mechanical adjustment of any vertebral articulation and contiguous articulations beyond the normal passive physiological range of motion.

It is not uncommon for some patients to experience some increased discomfort after an adjustment. If that happens, I agree to apply ice on the area and rest. If I am concerned about this discomfort or develop any new symptoms, I may call the office at 210-927-2095. If I am out of town or unable to contact the doctor, I may present myself to the emergency room.

As in all health care, there are some risks to treatment including but not limited to, muscle sprain/strain, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks or complications; however the doctor will do his best to explain the problem.

Based on the facts and findings as presented to the doctor at the time of treatment, I agree to rely on the doctor to exercise judgment which is based on my best interest and well-being during the course of the procedures.

I have read the above consent with the doctor and/or staff as indicated by my signature. I have had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

**Patient Signature**_____ **Date**_____

## Acknowledgement for Consent to Use and Disclosure of Protected Health Information

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by **SANA Wellness & Health, dba Peters Chiropractic Clinic** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

**Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change privacy practice**

This office reserves the right to modify the privacy practices outlined in the Notice.

**Signature**

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it. I am aware these offices DOES NOT have open therapy areas.

_____ _____ _____

**Name of Patient (print)** **Signature of Patient** **Date**

_____ _____ _____

**Signature of Patient Representative** **Date** **Relationship of Patient Representative**

_____

**Others we may release your PHI to**

Brenda Hernandez 01/01/2018

**Office Representative** **Date**

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## Suhail Daraiseh, D.C.
## SANA Wellness & Health, LLC, dba, Peters Chiropractic Clinic

**ACKNOWLEDGEMENT FORM**

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Peters Chiropractic Clinic's "Notice of Privacy Practices" has been provided to me.

I understand that I have the right to review Peters Chiropractic Clinic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for Peters Chiropractic is also provided on request at the front desk of the practice. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information what will occur in my treatment, payment of my bills or in performance of health care operations of Peters Chiropractic Clinic. This Notice of Privacy Practices also describes my rights and Peters Chiropractic Clinic's duties with respect to my protected health information.

Peters Chiropractic Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.

_____ _____ _____

Signature of Patient or Personal Representative Name of Patient or Personal Representative Date

Brenda Hernandez, Peters Chiropractic Clinic, Office Representative

**Office Policies**

Welcome to **Peters Chiropractic Clinic, where *Helping You Reach Optimal Health* is our mission.** We offer 3 primary services:

**Chiropractic Care**
**Nutritional Support**
**Foot Orthotics** (Functional Orthotics)

There is much to learn about these important areas which lead to better health, and focusing on these areas will add life to your years.

Below are our office procedures regarding appointments / walk-in, and payments. Please take the time to read and become acquainted with them.

1. ***New Patient Care Services***:
New patient services consist of an X-ray of the area of complaint(s), exam(s), and chiropractic adjustment(s) in or near the area of pain. The reason X-Ray(s) is/are taken is to allow the doctor to determine the symptoms/reasons for your pain. The doctor will provide a verbal report of the X-Ray to you as part of your visit. Following the X-Ray report, the doctor will perform an exam of the area and the first adjustment(s) where appropriate to help reduce your pain. Finally, the doctor will discuss a treatment plan to help restore and align your body toward wellness, and will answer any questions you may have.

2. ***Follow-up Patient Care Services***:
After initial consultation and depending on the gravity of the condition, you most likely will need follow-up visits. A treatment plan will involve of a number of follow up visits to correct your condition. The doctor will review your treatment plan with you to determine what is best for you. Each patient is different, so not all treatment plans are the same. If you are released from your treatment plan, or have been away longer than 60 days without seeing the doctor, or you have a new pain condition, you will be required to complete a **New Condition Form**. Under this situation, it is possible a new X-ray will be needed of the area to determine the new cause of pain. Procedures explained above in the new patient section will apply.

***3. Office Policy Regarding X-Rays***
All new patients are required to have an X-Ray taken only where your pain originates. The X-Ray(s) is/are good for two years if no new incident occurs to the same area(s) within that time-frame. If an established patient has been away longer than 1 year or has a new pain condition, an X-Ray may be required. If you wish to take additional X-Rays, additional fees will apply. If you wish to take your X-Ray to another physician, you must complete a Medical Release Form. To complete this process, we require 48 hours notice.

***4. Patient Payment Policy***
**We require 100% payment of all charges due on each visit. We accept Cash, Debit, Visa, MasterCard, Discover, and American Express only.**

***5. Our Policy on Health Insurance***
Health insurance is not required to be treated at Peters Chiropractic Clinic. If you wish to submit your services to your healthcare insurance, we can provide you with a receipt for you to submit your treatment claim directly to your insurance.

***6. Office Policy on Appointments & Walk-ins***
In order to better serve our patients, we schedule appointments in advance. Walk-ins are welcome but patients with appointments will have first priority. If you are unable to keep your scheduled appointment, we ask that you cancel it at least 24 hours in advance. If you are running late, please contact us to let us know. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. If you do not contact us as stated above, you will be charged a **$25 missed appointment fee for appointments on Tuesday through Friday, and $50 on Saturday.** Please help us help others. Our office hours are posted on our website: www.peterschirosa.com.

I have read the Peters Chiropractic Clinic Policies and I will honor them.

_____ _____
Patient's Signature Date