SANA WELLNESS & HEALTH

1032 S. Alamo Street, San Antonio, TX 78210 210-927-2095

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:_____

Complaint(s) 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: Aching Burning Cutting Deep Dull Sharp Shooting Throbbing Nagging Numbness Persistent

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?_____

Severity of Pain: Please Circle 0 1 2 3 4 5 6 7 8 9 10

(No pain) (Extreme pain)

How frequent is complaint present, how long does it last?_____

Does anything aggravate the condition? Yes or No: _____

Does anything make the complaint better? Yes or No: _____ Do you have flat-feet, or pain in your feet? Yes or No_____

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_____

Have you broken any bones? Which ones? _____

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

Date _____ Type of Surgery _____

_____ _____

F. FEMALES ONLY: Pregnancies / Outcomes

Pregnancies / Date of Delivery _____ Outcome _____

_____ _____

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 (1): Cancer Heart Diabetes Other _____ Sibling (2): 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): _____

How is your diet? ***(Circle)*** Healthy Healthy Sometimes Fast-Food

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_____

Patient Read and Affirm Informed Consent to Chiropractic Adjustments & Care _____ (Patient Initials)

Office Policy on Appointments

In order to better serve our patients, we schedule appointments in advance. 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.sanawellnesshealth.com

Patient Initials _____

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, LLC** 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 01/01/2021

Office Representative **Date**

Suhail Daraiseh, D.C.
SANA Wellness & Health, LLC
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_____, SANA Wellness & Health, LLC, Office Representative