CHIROPRACTIC WELLNESS CENTER

HISTORY FORM

Name____ Age________ Sex M F Date__________________

Address_________________________________ _______ City_____________________ State_____ Zip_____________

DOB______________________ SS#_________________________ Referred by___________________________

H. Phone_______________________ W. Phone_____________________ C. Phone________________________

Ins. Carrier_____________________ Primery Insurer______________________ DOB(Primary)__________________

Marital Status □ S □ M □ D □ W Occupation________________________ Employer________________________

Have you ever received Chiropractic Care? Yes___ No___ If yes, when? __________________________________

Chief Complaints:

Location of Complaint/Pain: ____

____

What was the initial cause of this complaint: ____

When did the complaint begin? ____

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

Do you have any numbness or tingling in your body? Yes___ No___ If yes, where? ____________________________

Does this complaint/pain radiate or travel (shoot) to other areas of the body? Yes___ No___

If yes, where? ____

Health History:

Do you take vitamins or supplements? Yes___ No___ Type and how often? __________________________________

Do you take Medications: ____

Condition/s you are taking medication for: ____

Smoking? Yes___ No___ Alcohol use. Yes___ No___ How often? ____

FEMALES: Are you currently pregnant? Yes___ No___ Possibly___

Are there any other health concerns you would like to address/discuss? Yes___ No___ If so, explain:_______________

____

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 to provide me/child with Chiropractic Care, in accordance with the state's statues.

Patient/Parent/Guardian Signature: X____Date: _______________________

Chiropractic Wellness Center
5225 Canyon Crest Dr. Ste 17
Riverside, CA 92507
Tel: (951)222-2002
Fax: (951)686-8083

Notice of Privacy Practices
Patient Acknowledgement

Patient Name:____ Date of Birth:______________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purpose: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and brief description of how I exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserve the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:____ Date:________________

Relationship to patient (if signed by a personal representative of patient):__________________________

Form # PRV1-3