ABOUT THE PATIENT.

(Mana Chiropractic, 21168 Redwood Rd Suite 100, Castro Valley, CA, 94546)

Name _____ Today's Date_____ Birthdate _____

Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

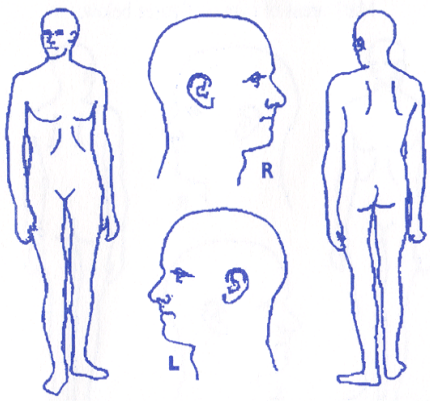
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

(Mana Chiropractic, 21168 Redwood Rd Suite 100, Castro Valley, CA, 94546)

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking:_____

_____

_____

2. Please list all doctors you are currently seeing:

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ **Was any care received?**_____

5. List any past work injuries: _____ **Was any care received?**_____

6. List any past sport, recreational, or home injuries_____

7. Please describe any past conditions and treatment received:

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to

HIPAA Acknowledgement of Private Practice

My signature confirms that I have been informed of the rights to privacy regarding my protected health information, under the ***Health Insurance & Accountability Act*** of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my provider has the right to change the *Notice of Privacy Practices* and I may contact this office at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how much private information is used or disclosed to carry out treatment, payment or health care operation and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to patient _____

Dependent family members also covered by this Acknowledgment:

_____

_____

_____

For Office Use Only

We are unable to obtain the patients acknowledgement of our Notice of Privacy Practices due to the following reason:

D The patient refused to sign

D Communication barriers

D Emergency situation

D Other

Employee Signature _____

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MANA CHIROPRACTIC

Dear Patient: Every type of health care is associated with some risk of potential problems. This includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before considering treatment. This is called informed consent.

Informed Consent for Treatment Care

1. I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic testing including but not limited to X-rays, nerve studies, ultrasounds, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic care who now or in the future provide treatment at the clinic or office listed below or any other office or clinic.

2. I have had an opportunity to discuss with the doctor of chiropractors named below and/or with other offices or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

3. I understand that the chiropractic will use his/her hands as a mechanical device upon my body to adjust a joint and there may be an audible "pop" or click as a result of joint movement

4. The practice of health care is not an exact science but relies upon information related by the patient, information gathered during the examination (and the doctor's interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic health care is no different

5. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure or any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedure, which she/he feels at the time to be in my best interest.

6. Though infrequent, as with any health procedures there are certain complications, which may arise during chiropractic health. These complications include soreness/strain, dislocation, fracture, disc injuries, cerebrovascular accidents, physiotherapy, burns, or soft tissue injuries. These complications are extremely rare occurrences.

7. Chiropractic is a system of health care delivery, therefor as with any other health care delivery system, we cannot promise a cure for any symptoms, disease, or conditions as a result of treatment. In this clinic we will give you our best care

8. I understand that there are other forms of treatment including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care by Mana Chiropractic.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedure. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Witness Name: _____ Date: _____

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