

FFSC New Patient Intake & History

Minor Single Married Separated Divorced Widowed Partnered _____ years

Last Name		First Name		Middle	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address			City	State	Zipcode
SSN	Email	Birthdate	Age	Home Phone	Cell Phone
Occupation	Employer/School		Employer/School Address		Employer/School Phone
Spouse's Name	Spouse's SSN		Spouse's Employer		Spouse's Phone
Emergency Contact Person		Relationship to Patient		Home Phone	Cell Phone
Health Insurance Carrier		Insured's Name		Insured's Birthdate	Relationship to Patient
Medical ID Number	Group / Policy / Plan / Control #			Who may we thank for your referral?	

Area of Complaint (*Auto Accident, Work Injury, or other Personal Injury Cases require special forms. Please ask front desk.)

Please describe the problem you are here for and how it began. **Date of Onset:** _____

Location of pain: Left Right Both Center

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Stabbing Burning Tingling Cramps Stiffness Swelling Muscle Spasms

Other: _____

Severity: Mild Mild to Moderate Moderate Moderate to Severe Severe

Does this interfere with your: Work Sleep Daily Routine Recreation None

What makes it feel better: Medication Lying Down Standing Sitting Stretching

Range of Motion Nothing Other: _____

What makes it feel worse: Bending Movement Twisting Weight Bearing Movements

Neck Flexion Sneezing Housework Sitting Standing Walking Driving

Chewing Opening/Closing Mouth Range of motion Pushing/Pulling Lifting

Bright Light Loud Noises Working Reading

Does the pain radiate to other body parts: No Yes If yes, where: _____

When is it at it's worst: Morning Afternoon Evening Nighttime After Light Activities

After Moderate Activities Other: _____

Are your symptoms associated with: Dizziness Nausea Visual Problems Bright Light

Ringing/Buzzing Ears Sensitivity Loss of Balance Other: _____

What other treatment have you received for this condition: Chiropractic Medical

Physical Therapy Other: _____

Were x-rays or other types of imaging taken: No Yes If yes, which type & when: _____

DATE _____ X-RAY TYPE _____

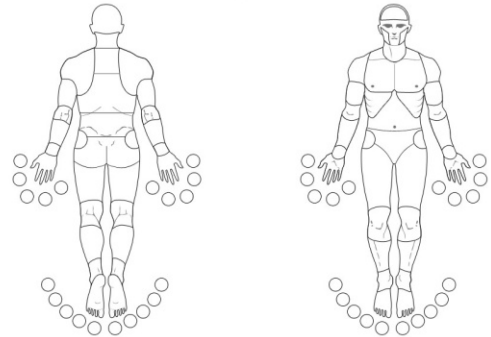
Where are these now located: _____

Please mark what you are feeling in the areas on this body.

Use the symbols below to indicate the sensations.

Numbness **Pins & Needles** **Burning** **Aching** **Stabbing**
 ----- o o o o o x x x x x ***** / / / / /

Make sure to mark any areas of radiation and include all affected areas.



Circle the severity of your symptoms on a scale of 0 to 10 (10 being the worst pain you have ever felt)

1 2 3 4 5 6 7 8 9 10

SLEEPING

Type of mattress you sleep on: _____

Type of pillows you use: _____

Sleeping position: Back Stomach Right Side Left Side

WOMEN ONLY

Are you pregnant or think you may be: No Yes

If yes, how many weeks/months: _____

Are you suffering from menstrual disorders: No Yes

If yes, which disorder(s): _____

How many pregnancies: _____

How many children do you have: _____ Boys _____ Girls

MEDICAL HISTORY INFORMATION

Do You Have a Family Doctor: No Yes If yes, name of Doctor: _____ Date of last visit: _____ Date of last exam: _____

Address: _____ City: _____ State: _____ Zipcode: _____

Have you had any major falls or accidents: No Yes If yes, please describe: _____

Please list ALL medications (prescription and over-the-counter) that you are currently taking: _____

Please list any nutritional supplements you are taking: _____

Have you had surgeries in the last 5 Years: No Yes If yes, date of last surgery: _____

Reason for Surgery: _____

Past or Present Illness/Conditions (If checked, please write PAST or NOW):

- | | | | | | | |
|---|--|---|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Polio | <input type="checkbox"/> STD'S |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herpes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bullimia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Thyroid Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Goiter | <input type="checkbox"/> HIV/ARC | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cirrhosis/Hepatitis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mental/ Emotional Difficulty | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Spinal Disc Disease | <input type="checkbox"/> _____ |

Family History of Illness:

- | | | | | | | |
|---|--|---|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Polio | <input type="checkbox"/> STD'S |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herpes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bullimia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Thyroid Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
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Type of Cancer: Breast Lung Other: _____

Social History:

Alcohol? No Yes Cigarettes? No Yes Caffeine? No Yes Exercise? No Yes
Drinks per week: _____ Packs per day: _____ Drinks per day: _____ Hours per week: _____ Light Moderate Strenuous

Miscellaneous: _____

AUTHORIZATION FOR TREATMENT

I have answered the above questions accurately to the best of my knowledge.
I authorize Dr. Coronel to perform examination and treatment procedures on me that are deemed appropriate for my condition.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.



FFSC Office Policies & Fees

Welcome to our office—we thank you for your trust! Our mission is to serve the greater East Bay community with exceptional family & sports chiropractic care. Dr. Coronel treats all of her patients with a personal, integrative approach and by using chiropractic adjustments, physiotherapies, muscle-release techniques, rehabilitation protocols, and patient education, she is committed to keeping you and your families performing at your optimum health and wellness.

GROUP INSURANCE

If you have health insurance that you believe may cover chiropractic in this office, we will verify your insurance coverage for you as a professional courtesy. Once your eligibility and coverage is determined we will file all insurance claims for you to the extent that your policy permits. You are responsible for paying your deductible, co-payment and non-covered supplements, supplies, and services at the time they are rendered.

CASH

Please inquire about our Simple Plan, which includes discounted fees for patients who are not covered by insurance or who choose not to use their insurance. We request 100% of the first visit be paid at the time of the first visit. All future visits must be paid for at the time of service. If your financial situation requires special arrangements, please speak with Dr. Coronel.

WORKERS' COMPENSATION

Chiropractic services are covered by Workers' Compensation law, and you should be covered 100%, as long as your employer is aware you were injured on the job, you have completed the required papers with your employer, your employer has no objection to your receiving care here, and is covered by Workers' Compensation Insurance. You are responsible for non-covered items such as supplements and supports that are not a direct result of the accident. These items are to be paid for at the time they are received.

MEDICARE

Dr. Coronel is a Participating Provider with Medicare therefore, we are required to bill Medicare for services. Medicare does require that you pay for X-rays, examinations, supplements, supplies, physical therapy and any other non-covered services, and therefore you will be asked to pay for these services at the time you receive them. You will also be required to pay an annual deductible and small co-payment. If you have a supplemental insurance policy that covers chiropractic we will bill them for you if Medicare does not. Medicare will send payment directly to our office. You will also be required to pay all visits in full once Medicare stops paying Dr. Coronel.

PAYMENT

- Payment is due when services are rendered unless arrangements are made in advance.
- We accept Cash, Check, Visa, and Mastercard. Returned checks result in a \$10.00 charge.
- An unpaid balance greater than 60 days will result in your account being sent to collections.

MISSED APPOINTMENTS

There will be a \$35 charge for missed appointments with the Doctor if less than 24 hours notice is given.

IT MUST BE UNDERSTOOD:

1. This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.
2. The clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.
3. If you have more than one insurance and would like to bill it, we will supply you with a copy of our insurance billing to use in billing your second insurance.

I understand and agree to the above policies. I understand that all information in my chart is confidential. I authorize Dr. Coronel and office staff to release pertinent information to insurance companies and other health care providers as indicated for my health care.

Printed Name

Signature

Date Signed

If you are a minor or being represented by another party:

Name of Legal Representative

Signature of Legal Representative (e.g., attorney-in-fact, guardian, parent of a minor)

Relationship to Patient

Witness



FFSC Patient Consent to Treat

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. I _____ do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Nontreatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Printed Name

Signature

Date Signed

If you are a minor or being represented by another party:

Name of Legal Representative

Signature of Legal Representative (e.g., attorney-in-fact, guardian, parent of a minor)

Relationship to Patient

Witness



FFSC Patient Consent for Use and/or Disclosure of Protected Health Information

_____ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Fremont Family & Sports Chiropractic has provided me with their Privacy Notice prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary to obtain payment for that treatment and to carry out its health care operations. I understand that the Practice may use or disclose personal and health information about me in the following ways:
 - a. My PHI, including my clinical records, may be disclosed to another health care provider or hospital, if it is necessary to refer me for further diagnosis, assessment, or treatment.
 - b. My health care records, as well as my billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or my employer (if they are responsible for the payment of services).
 - c. My name, address, phone number, and my health care records may be used to contact me regarding appointment reminders, to provide information about alternatives to my present care, or to other health related information that may be of interest to me.
2. I understand the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
3. The Practice reserves the right to alter or amend its privacy notice that are described in its Privacy Notice, in accordance with applicable law. If changes are made to the privacy notice, I understand these changes will apply for all my health information in the Practice’s files and that the Practice will notify me in writing as soon as possible following the changes.
4. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
 - a. a postcard mailed to me at the address provided by me; and
 - b. telephoning my home and leaving a message on my answering machine or with the individual answering the phone.I understand that I also have the right to refuse to provide authorization for this office to contact me regarding these matters. If I do not provide the office with this authorization, it will not affect the care provided to me or the reimbursement avenues associated with my care.
5. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations. I understand that under federal law, the office is also permitted or required to use or disclose my PHI without my consent or authorization in the following circumstances:
 - a. If the office is providing health care services to me based on the orders of another health care provider.
 - b. If the office provides services to me in an emergency.
 - c. If the office is required by law to provide care to me and they are unable to obtain my consent after attempting to do so.
 - d. If there are substantial barriers to communicating with me, but in their professional judgment believe that I intend for them to provide care.
 - e. If the office is ordered by the courts or another appropriate agency.

I understand that any use or disclosure of my PHI, other than as described in the examples outlined above, will only be made upon my written authorization.

6. I understand that the Practice will normally provide information about my health care to me in person at the time I receive chiropractic care from them. I further acknowledge that the Practice may also mail information to me regarding my health care or the status of my account. I understand that if I would like to receive this information at an address other than my home, or if I would like the information in a different form, I will advise the Practice in writing as to my preferences.
7. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding to the Practice.
8. I understand that this Consent is valid for seven years or for as long as the information stays in our files. I understand that requests to inspect, copy, or amend my health related information will be provided by me in writing and a fee may be involved. In addition, I understand that I have the right to request an amendment to my health information. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understand that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
9. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
10. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.
11. I understand that the Practice is required by state and federal law to maintain the privacy of my patient file and my PHI. I also understand that the Practice is required to provide me with this notice of their privacy practices with respect to my PHI and that they are further required by law to abide by the terms of this notice while it is in effect.
12. I understand that information that the Practice uses or discloses, based on this privacy notice, may be subject to re-disclosure by the person or persons to whom the Practice provides information to. I understand that if I would like further information about the Practice privacy policies and practices, I can contact:

Dr. Melanie S. Coronel, D.C., C.C.S.P.
 Fremont Family & Sports Chiropractic
 39809 Paseo Padre Parkway, Fremont, CA 94538
 P: 510.440.0410 | F: 510.440.0411

This notice is effective as of December 1, 2007. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice, I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

 Printed Name

 Signature

 Date Signed

If you are a minor or being represented by another party:

 Name of Legal Representative

 Signature of Legal Representative (e.g., attorney-in-fact, guardian, parent of a minor)

 Relationship to Patient

 Witness