Haque Chiropractic Inc.

WELLNESS | LIFESTYLE | FITNESS

1855 First Street Livermore, CA 94551 (925) 960-1960 www.haquechiropractic.com

Welcome! We are delighted to see if we can help you live better without drugs and surgery. Please fill out the following information as completely as you can so we can get to know you and your health concerns.

Date: _____ SS # _____

Full Legal Name _____DOB _____

Gender: **M / F** Marital Status: **M S D W** Children: **Y / N** if yes how many _____

Height _____ Weight _____ Age _____

Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____Cell _____

Your Employer _____ Phone _____

Work Address _____

City _____State _____ Zip_____

Spouse's name _____Phone _____

Emergency contact person _____

Relationship _____Phone # _____

What type of work do you do? _____How did you hear about us? _____

Are you insured? _____ Type: _____

Financial information: Who is responsible for this account? _____

Reason for Seeking Care: Pain/Injury Related **YES NO** Wellness/Health Maintenance **YES NO**

Accidents: Please list other accidents, include dates. (Car, bicycle, motor cycle, sports, falls at home or work)

_____

Illness: Please list and include dates._____

Surgery/Conditions: Please list major surgeries, broken bones or conditions, include dates.

_____

_____

What concerns you most about your problem and/or what does it prevent you from doing? _____

_____

What makes it feel better? _____

What makes it feel worse? _____

Medications: Please list prescriptions & over the counter medications you are currently taking & their purpose.

_____

_____

Have you been to a chiropractor before? YES NO

Briefly describe that experience: _____

_____

_____

Did the last chiropractor adjust your spine? YES NO If yes, was there a "popping" sound when they adjusted you? YES NO If yes please explain to the best of your ability what causes that "popping" sound.

_____

Expectations of care. How many visits to our office do you anticipate? _____

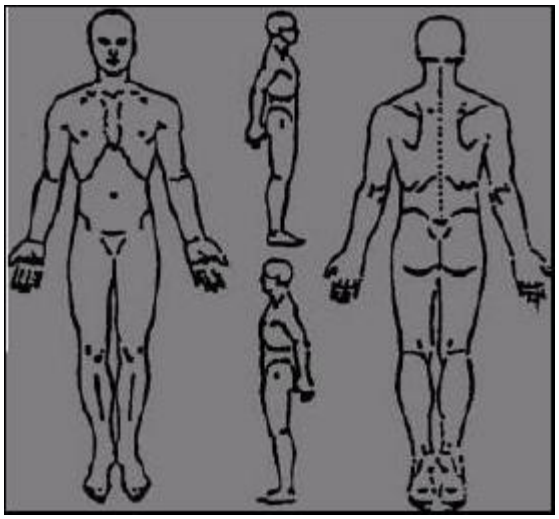
If you are here due to an injury or pain please describe what happened:

_____

_____

Please mark your areas of pain on the figures by indicating the appropriate location of pain and the symbol that best describes your discomfort.

Sharp & Stabbing	A
Dull & Achy	B
Pins & Needles	C
Numbness	D
Temperature Change	E



Please score all of the following on a scale of 1-10, based on your current condition.

Pain: 1=no pain, 10=worst pain you have ever had
Personal care:(washing, dressing, etc.)1=I can take care of myself with no pain, 10=I can't take care of myself at all
Lifting: 1=I can lift with no extra pain, 10=I can't lift at all due to
Reading: 1=I can read with no extra pain, 10= I can't read at all due to pain
Headaches: 1=no headaches, 10=worst headaches I have ever had
Concentration: 1=I can concentrate fully, 10=I can't concentrate at all
Work: 1=I can work as much as I want, 10=I can't work at all
Driving: 1=I can drive with no pain, 10=I can't drive due to pain
Sleeping: 1=I sleep fine, 10=I can't sleep at all

Please answer all questions. If you are not sure do your best.

Has your eyesight blacked out completely?……...	YES	NO
Have you fainted more than twice in your life?	YES	NO
Were you ever knocked unconscious?.....	YES	NO
Are you hard of hearing?	YES	NO
Do you have allergies?…….....	YES	NO
Have you ever coughed up blood?	YES	NO
Have you suffered frequent cramps in your legs? …….....	YES	NO
Has a doctor ever said you had heart problems?	YES	NO
Has a doctor ever said you had ulcers?.....	YES	NO
Does pressure or pain in your head often make life miserable?	YES	NO
Have you or a family member ever had convulsions or epilepsy? Who?.....	YES	NO
Did a doctor ever treat you for a tumor or cancer?	YES	NO
Are you frequently ill?...……...…….	YES	NO
Are you considered a nervous person?	YES	NO
Has a doctor ever said your blood pressure was too high...……...……	YES	NO
Have you been told you have osteoporosis?	YES	NO
Have you been told you have rheumatoid arthritis?..……..…….....	YES	NO

In our chiropractic office we provide many services for your health. To get an idea of what you want and expect please take the following survey.

How would you rate your current health? Poor Fair Average Good Excellent

Please score yourself from 1 to 10 below in each health category and then indicate if you are interested in receiving help in these areas. You can select as many or as few as you like.

Musculoskeletal pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)
I would like help and/or info on decreasing my pain: Yes No

Diet and nutrition: 1 2 3 4 5 6 7 8 9 10 (1 horrible diet, 10 excellent diet)
I would like help and/or info on improving my diet and nutrition: Yes No

Exercise program: 1 2 3 4 5 6 7 8 9 10 (1 horrible exercise habits, 10 excellent exercise habits)
I would like help and/or info on exercise: Yes No

Ability to sleep well: 1 2 3 4 5 6 7 8 9 10 (1 horrible sleeper, 10 excellent sleeper)
I would like help and/or info on getting a good nights sleep: Yes No

Stress level: 1 2 3 4 5 6 7 8 9 10 (1 no stress at all, 10 extreme stress)
I would like help and/or info on decreasing my stress: Yes No

Weight Loss/Fat Loss: 1 2 3 4 5 6 7 8 9 10 (1 constant trying to lose weight, 10 never)
I would like help and/or info on managing my weight: Yes No

Pharmaceutical drug intake: 1 2 3 4 5 6 7 8 9 10 (1 daily intake, 10 never)

I would like help and/or info on alternative solutions: Yes No

Energy Level: 1 2 3 4 5 6 7 8 9 10 (1 no energy at all, 10 endless energy)

I would like help and/or info on increasing my energy level: Yes No

Anti-aging: 1 2 3 4 5 6 7 8 9 10 (1 not concerned about skin and aging, 10 very concerned and want natural solutions)

I would like help and/or info on natural anti-aging solutions and glowing skin: Yes No

I have concerns about the following? (Circle)

Exercise Hormone Balance My Diet/Nutrition Weight Loss Supplements Toxicity Anti-aging

What is/are your health goals currently:

_____

_____

_____

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Low Blood Pressure	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Heart Attack	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Chest Pains	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Stroke	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Angina	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Heart Murmur	□	□ Depression
□	□ Wrist Pain	□	□ Congenital Heart Defect	□	□ Psychiatric Problems
□	□ Hand Pain	□	□ Heart Surgery/Pacemaker	□	□ Systemic Lupus
□	□ Hip Pain	□	□ Kidney Stones	□	□ Epilepsy
□	□ Upper Leg Pain	□	□ Kidney Disorders	□	□ Dermatitis/Eczema/Rash
□	□ Knee Pain	□	□ Bladder Infection	□	□ HIV/AIDS
□	□ Ankle/Foot Pain	□	□ Painful Urination	□	□ Thyroid Problems
□	□ Jaw Pain	□	□ Loss of Bladder Control	□	□ Rheumatic Fever
□	□ Joint Pain/Stiffness □	□	Prostate Problems	□	□ Tuberculosis
□	□ Arthritis	□	□ Abnormal Weight Gain/Loss	□	□ Shingles
□	□ Rheumatoid Arthritis	□	□ Loss of Appetite	□	□ Anemia
□	□ Cancer	□	□ Abdominal Pain	□	□ Difficulty Breathing
□	□ Chemotherapy	□	□ Digestive Problems	**For Females Only**	
□	□ Tumor	□	□ Loss of sleep	□	□ Birth Control Pills
□	□ Asthma	□	□ Ulcer/Colitis	□	□ Hormone Replacement
□	□ Chronic Sinusitis	□	□ Hepatitis	□	□ Pregnancy
□	□ Sinus Problems	□	□ Liver/Gall Bladder Disorder	□	□ Nursing
□	□ General Fatigue	□	□ Muscular Incoordination	□	□ Experience painful periods
□	□ Visual Disturbances	□	□ Dizziness	□	□ Have Irregular cycles
□	□ Other: _____			□	□ Have breast implants

By signing below I am giving permission for Haque Chiropractic doctors to perform an exam and x-rays if necessary for me. I also give permission for Haque Chiropractic to do a complimentary benefits check for the insurance card I have provided if applicable. I realize that the cost of my exam does not include any treatment, and if I am accepted as a patient by Haque Chiropractic I will be informed of the recommended treatment plan and the cost associated with accepting that plan.

Patient Signature_____**Date:** _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ Home Telephone _____
___ O.K. to leave message with detailed information
___ Leave message with call-back number only

☐ Work Telephone _____
___ O.K. to leave message with detailed information
___ Leave message with call-back number only

☐ Written Communication
___ O.K. to mail to my home address
___ O.K. to mail to my work/office address
___ O.K. to fax to this number

☐ Other _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

STOP HERE

Office use only below this line

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	**Disclosed to Whom** **Address or fax number**	**(1)**	***Description of Disclosure/*** **Purpose of Disclosure**	By Whom Disclosed	**(2)**	**(3)**

(1) Check this box if the disclosure is authorized
(2) Type key: T= Treatment Records P= Payment Information O= Healthcare Operations
(3) Enter how disclosure was made: F= Fax P= Phone E= Email M= Mail O= Other