New Practice Member Forms

THE WELL CHIROPRACTIC

Name: _____ Birthday_____ Age: _____ ○ Male ○ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

E-mail: _____ Social Security Number: _____

Occupation: _____ Employer's Name: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed Spouse's Name _____

Number of children and ages: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who may we thank for referring you? _____

Check All Current Problems You Have

○ Headache	○ Dizziness	○ Fibromyalgia	○ Throat Problems	○ Thyroid Problems
○ Neck Pain	○ Migraines	○ Epilepsy	○ Disc Problem	○ Kidney Problems
○ Jaw Pain, TMJ	○ Vertigo	○ Lupus	○ Digestive Problems	○ Difficulty Breathing
○ Shoulder Pain	○ Tremors	○ ADD/ ADHD	○ Liver Disease	○ Infertility
○ Upper Back Pain	○ Double Vision	○ Irritable Bowel	○ Diarrhea/Constipation	○ Other
○ Mid Back Pain	○ Loss of Balance	○ Ringing in Ears	○ Stomach Problems	_____
○ Low Back Pain	○ Blurred Vision	○ Fainting	○ Menstrual Disorder	_____
○ Hip Pain	○ Sinus/Drainage Problem	○ Depression	○ Asthma	_____
○ Knee Pain	○ Pain w/Cough/Sneeze	○ Anxiety	○ Ulcers	_____
○ Foot Pain	○ Chest Pain	○ Mood Changes	○ Gastric Reflux	_____
○ Numbness in Arms	○ Numbness in Fingers	○ Allergies	○ Heart Disorder	_____
○ Numbness in Legs	○ Numbness in Feet	○ Nervousness	○ Bladder Problems	_____

Have you tried other forms of treatment for these conditions? ○ No ○ Yes

If yes, please state what type of treatment: _____

Who provided it? _____ How long ago? _____ What were the results. ○ Favorable ○ Unfavorable

Please explain: _____

Check if you have ever been diagnosed with any of the following conditions:

○ Fracture	○ Dislocations	○ Scoliosis	○ Cancer	○ Seizures
○ Heart Attack	○ Stroke	○ Diabetes	○ Rheumatoid Arthritis	

List all surgical operations & years _____

_____

List prescription & non-prescription drugs you take: _____

_____

Were you ever in an auto accident? ○ Yes ○ No **If yes,** when? _____

Identify any other injury(s) to your spine, minor or major:

_____

Please identify the condition(s) that brought you to this office:

Symptom 1: ____

- On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

0 1 2 3 4 5 6 7 8 9 10

- When did the problem(s) begin? ______________________________
- When is the problem at its worst? O Morning O Afternoon O Evening O Late at night O Unchanged by time of day
- What % of the time do you feel it?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

- How did the injury happen? _______________________________________

____

- Have you had the symptom in the past? O No O Yes
- **If yes,** when was the first time you felt ______________________________
- Does the pain radiate? O No O Yes
- **If yes,** describe in detail where it radiates ___________________________
- What relieves your symptoms?

____

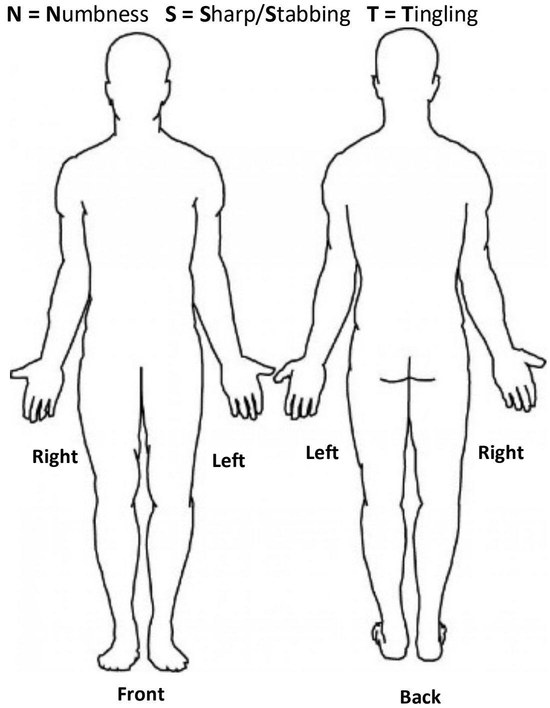
- What makes your symptoms worse?

____

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching

N = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling



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Symptom 2: ____

- On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

0 1 2 3 4 5 6 7 8 9 10

- When did the problem(s) begin? ______________________________
- When is the problem at its worst? O Morning O Afternoon O Evening O Late at night O Unchanged by time of day
- What % of the time do you feel it?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

- How did the injury happen? _______________________________________

____

- Have you had the symptom in the past? O No O Yes
- **If yes,** when was the first time you felt ______________________________
- Does the pain radiate? O No O Yes
- **If yes,** describe in detail where it radiates ___________________________
- What relieves your symptoms?

____

- What makes your symptoms worse?

____

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

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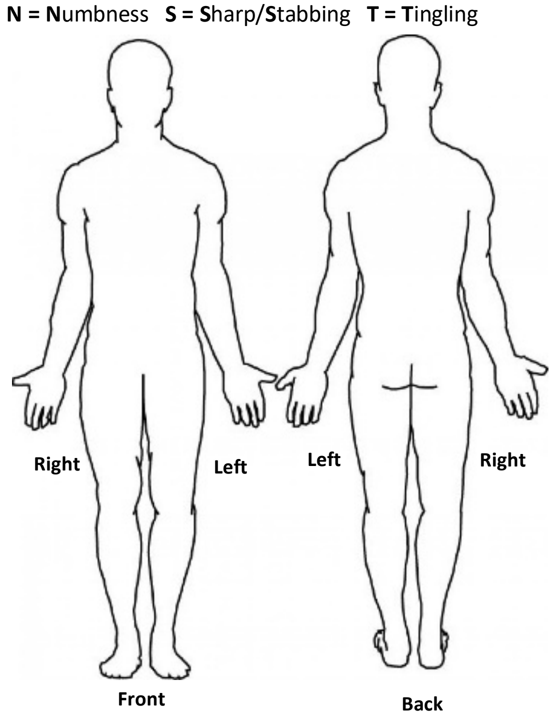

Please identify the condition(s) that brought you to this office:

Symptom 3: ____

• On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

0 1 2 3 4 5 6 7 8 9 10

• When did the problem(s) begin? ______________________________

• When is the problem at its worst? ○ Morning ○ Afternoon ○ Evening ○ Late at night ○ Unchanged by time of day

• What % of the time do you feel it?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

• How did the injury happen? _______________________________________

____

• Have you had the symptom in the past? ○ No ○ Yes

• **If yes,** when was the first time you felt ______________________________

• Does the pain radiate? ○ No ○ Yes

• **If yes,** describe in detail where it radiates ___________________________

• What relieves your symptoms?

____

• What makes your symptoms worse?

____

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

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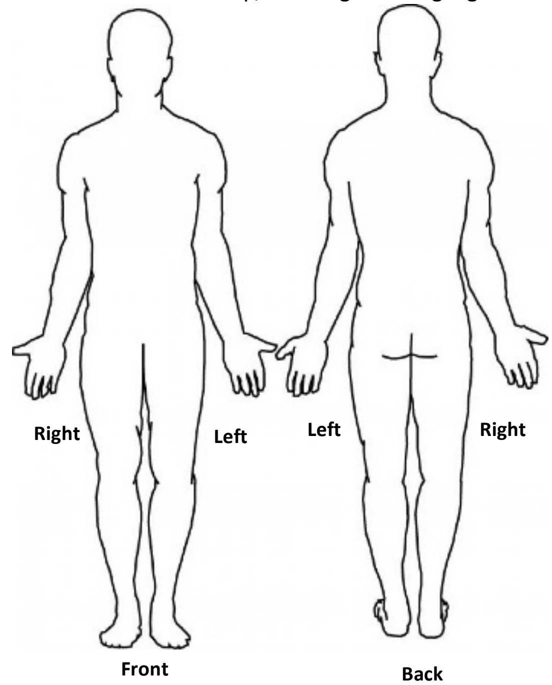

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Symptom 4: ____

• On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

0 1 2 3 4 5 6 7 8 9 10

• When did the problem(s) begin? ______________________________

• When is the problem at its worst? ○ Morning ○ Afternoon ○ Evening ○ Late at night ○ Unchanged by time of day

• What % of the time do you feel it?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

• How did the injury happen? _______________________________________

____

• Have you had the symptom in the past? ○ No ○ Yes

• **If yes,** when was the first time you felt ______________________________

• Does the pain radiate? ○ No ○ Yes

• **If yes,** describe in detail where it radiates ___________________________

• What relieves your symptoms?

____

• What makes your symptoms worse?

____

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

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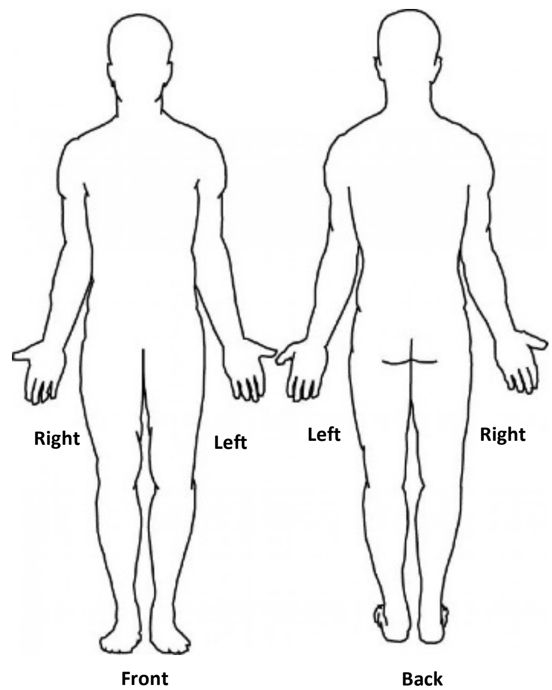

*Name*_____ *Date*_____ *Hojin Seo, DC, The Well Chiropractic, 2940 Westwood Blvd, Ste2, Los Angeles CA 90064*

Quadruple Visual Analogue Scale

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

***Example:** *A: Headache* *B: Neck* *C: Low Back*

No Pain — C — A — B — Worst Possible Pain

0 1 (2) 3 4 (5) 6 7 (8) 9 10

A: _____ B: _____ C: _____

1. What is your pain **RIGHT NOW**?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE PAIN**?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Other comments:

_____

_____

_____

Score: #1_____+ #2_____+ #4_____ = _____/3 x 10 = _____

Examiner Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activities	**No Effect**	**Painful (can do)**	**Painful (limits)**	**Unable to perform**
Carry Children/Groceries				
Sit to Stand				
Climb Stairs				
Pet Care				
Extended Computer Use				
Lift Children/Groceries				
Read/Concentrate				
Getting Dressed				
Shaving				
Sexual Activities				
Sleep				
Static Sitting				
Static Standing				
Yard work				
Walking				
Washing/Bathing				
Sweeping/Vacuuming				
Dishes				
Laundry				
Garbage				
Driving				
Other				

*Patient Signature*_____ *Date*_____

Family History

1. Does anyone in your family suffer with the same condition(s)? ○ No ○ Yes **If yes,** whom?
○ grandmother ○ grandfather ○ mother ○ father ○ sister(s) ○ brother(s) ○ son(s) ○ daughter(s)
Have they ever been treated for their condition? ○ No ○ Yes ○ I don't know

2. Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes: _____

Social History

1. Smoking: ○ cigars ○ pipe ○ cigarettes How often? ○ Daily ○ Weekends ○ Occasionally ○ Never
2. Alcoholic Beverage: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never
3. Recreational Drug use: ○ Daily ○ Weekends ○ Occasionally ○ Never
4. Hobbies - Recreational Activities - Exercise Regime: How does your present problem affect?

Please Explain: _____

Notice of Privacy Practices

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

Uses and disclosures:

- Treatment purposes - use your health information and share it with other health care providers who are treating you.
- Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
- Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
- Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
- Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
- For health research purposes.
- Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
- For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
- Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
- Emergency – in the event of a medical emergency we may notify a family member.
- Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
- Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

Your rights:

- To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
- To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- To request confidential communications (contact you in a specific way or send mail to a different address).
- To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
- To receive an accounting of disclosures (those with whom we've shared your information).
- To receive a paper copy of the extended detail Notice of Privacy Practices.
- To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- To file a complaint if you feel your rights are violated.

Patient Signature: _____ Date: _____

Informed Consent For Chiropractic Care

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at The Well Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Print Name _____ Signature_____ Date_____

If this health profile is for a minor/child, please fill out and sign below

Name of Practice Member Who is Minor/Child_____

I authorize Dr. Hojin Seo, DC and any and all The Well Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

Guardian Signature_____ Guardian Relationship to Child_____ Date_____

X-rays/Imaging Studies

The doctor will explain that the purpose of the x-ray about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "Unusual finding" when reviewing x-ray, I will be informed. I then, must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

At your request, we will provide you with a copy of your x-rays on a CD, which will be available within 72 hours during any regular office hours day.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Print Name _____ Signature_____ Date_____

FEMALES ONLY:
I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

Patient Signature_____ Date_____