

PATIENT INFORMATION

Referred By _____

Name _____ Birth Date: _____ Age: _____ Sex: M / F

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Driver's License #: _____ Social Security #: _____ Marital Status: _____

Occupation: _____ Employer: _____ Years Employed: _____

In Case of Emergency, Please Contact _____ Phone: _____ Relation: _____

Please fill out insurance info, if applicable and hand insurance card to receptionist to copy.

Name of insured: _____ Insurance Company: _____ Phone: _____

Policy #: _____ Group #: _____ Member #: _____ Cert #: _____

Agent _____ Medicare #: _____

Reason For Today's Visit: _____

Please Briefly Describe What Happened: _____

How long have you had this condition? _____ Have you had this or a similar condition in the past?: _____

What aggravates this condition?: _____

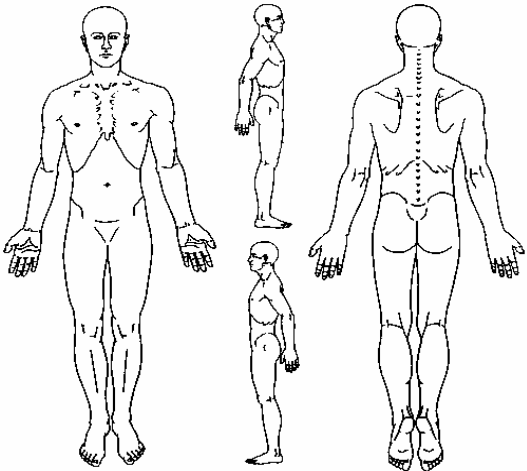
Is this condition getting progressively worse? YES NO Constant Comes & Goes

Are you seeing other Doctors for this condition? _____ Length of time under care _____ Did it help?: _____

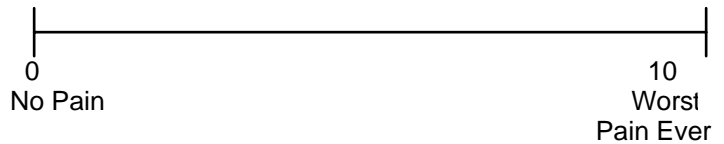
Doctor Name: _____ Address: _____ Phone #: _____

Type of Doctor: _____ (ie. Neurologist, Orthopedist, etc.) Any Physical Therapy? _____

ON THE DIAGRAM BELOW, PLEASE INDICATE WHERE YOU ARE EXPERIENCING PAIN OR OTHER SYMPTOMS. A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing O=Other



Please indicate level of pain by marking on the scale below:



Have you seen a Chiropractor before _____

What type of treatment did you receive?: _____

What did you like? _____

What did you dislike? _____

List Current Medications Taken: _____

List Current Non-Prescription Drugs/Vitamins Taken: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable.

Patient Signature: _____ Date: _____ Staff Initial: _____

IMPORTANT: Please check (X) all present symptoms.

HEAD:

Headache

- sinus (allergy)
- entire head
- back of head
- forehead
- temples
- migraine
- Head feels heavy
- Loss of memory
- Light-Headedness
- Fainting
- Light bother eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

NECK:

- Pain in neck
- Neck pain with movement
 - forward
 - backward
 - turn to left
 - turn to right
 - bend to left
 - bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

ARMS AND HANDS:

- Pain in upper arm
- Pain in elbow
- Movement aggravated
- Tennis elbow
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins and needles in arms
- Sensation of pins and needles in fingers
- Numbness in arms (R-L)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Loss of grip strength

SHOULDERS:

- Pain in shoulder joint (R-L)
- Pain across shoulders
- Bursitis (R-L)
- Arthritis (R-L)
- Can't raise arm
 - above shoulder level
 - over head
- Tension in shoulders
- Pinched nerve in shoulder (R- L)
- Muscle spasms in shoulders

MID BACK:

- Mid-back pain
- Location _____
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

CHEST:

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

ABDOMEN:

- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:

- Low back pain
- Upper lumbar
- Lower lumbar
- Sacroiliac
- Low back pain is worse when:
 - Working
 - Lifting
 - Stooping
 - Standing
 - Sitting
 - Bending
 - Coughing
 - Lying down (sleeping)
 - Walking
- Pain relieved when _____
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIP, LEGS, AND FEET:

- Pain in buttocks
- Pain in hip joint
- Pain down leg
- Pain down both legs
- Knee pain
 - inside
 - outside
- Leg cramps
- Cramps in feet
- Pins and needles in legs
- Numbness of leg
- Numbness of toes
- Feet feel cold
- Swollen ankles
- Swollen feet

WOMEN ONLY:

- Menstrual pain _____ (where)
- Cramping
- Irregularity
- Cycle _____ days
- Birth control _____ (type)
- Hysterectomy
- Genital cancer _____
- Discharge
- Menopause
- Tumors
- Abortions
- Are you or do you think you are pregnant?

MEN ONLY:

- Urinary frequency _____
- Difficulty in starting _____
- Night urination
- Prostrate pain/swelling

GENERAL

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep _____ hrs/night
- Loss of sleep _____ hrs/night
- Loss of weight _____ lbs
- Gain weight _____ lbs
- Coffee _____ cups/day
- Tea _____ cups/day
- Cigarettes _____ pack/day
- Other _____
- Diabetes
- Hypoglycemia

List any Surgeries below:

Patient's Initial: _____ Date _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read () or have had read to me () the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

I understand that Healthworks Chiropractic uses an open room adjusting approach. If this approach is unfavorable or undesirable to me, I understand that private rooms will be available upon request.

Print Name(s) of Doctor Treating This Patient

James K. Lyons, DC



182 S. MAIN ST. MILPITAS, CA 95035
PH: 408.262.7000 FAX: 408.262.7002

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient

Date

Signature of Patient

Date

Signature of Patient's Representative

Date

Witness to Patient's Signature

Date

Translated by

Date

NOTICE OF PRIVACY PRACTICES

NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

NOTICE OF PRIVACY PRACTICES

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Stephanie Chiu, Office Manager
182 S. Main St., Milpitas, CA 95035
Ph: 408.262.7000 Fax: 408.262.7002

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Healthworks Chiropractic, staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 04, 2006.

Printed Patient Name _____ Date _____

Signature _____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____