CHIROPRACTIC REM·E·DY

RESOLVE • CORRECT • REPAIR • MEND

3607 W Magnolia Blvd Suite C

Burbank, CA, 91205

Jenna Vitale MATCM, LAc **Katie Star LAc** **Joseph Oh LAc, RPh**

Name:_____ Date_____

Phone Number:_____ DOB:_____

Address:_____

City _____ State _____ Zip Code_____

Sex M / F Marital Status M____ S____ D____ W_____ Email _____

Occupation:_____ Employer: _____

Emergency Contact:_____ Phone#_____

Health Insurance Provider: _____

Who were you referred by? _____

Please share your focus, goals and intentions for this treatment in order of priority:

1_____

2_____

3_____

Please indicate if you have any of the following:

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Believe you are or may be pregnant
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Other:_____

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List all major childhood and adult illnesses:

_____

_____

Have you had any surgeries, major accidents or injuries, please explain:

_____

_____

List all medications or supplements, including herbs and vitamins you are currently taking:

_____

_____

Do you have any allergies? If so, please list

_____

Describe your regular exercise program. How many times per week?

_____

_____

Are you on a restricted diet? _____ What kind?

_____

_____

Sources/Amounts of : Caffeine _____Alcohol _____ Tobacco _____

What is your primary source of stress?

_____

_____

What can we do to make you happier?

_____

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PLEASE CHECK ALL SYMPTOMS THAT PERTAIN TO YOU AT THIS TIME.

□ Cold hands/feet
□ Fatigue
□ Feverish in the afternoon or flushes
□ Heat sensation in hands, feet, chest
□ Night sweats
□ Catch colds easily
□ Sweats easily during daytime
□ Dizziness
□ See floating black spots

_____

□ Palpitations
□ Sore on tongue
□ Restlessness
□ Anxiety
□ Chest pain
□ Insomnia

_____

□ Cough
□ Sinus congestion
□ Dry mouth, throat, nose, or skin
□ Allergies seasonal or food
□ Chills and fever
□ Stiff neck/shoulders
□ Sore throat
□ Difficult breathing

_____

□ Low appetite
□ Loose stools
□ Constipation
□ Abdominal bloating or gas after eating
□ Feeling tired after eating
□ Prolapsed organs (previously diagnosed)
□ Bruises easily
□ General feeling of heaviness in body
□ Mental heaviness or fogginess
□ Swollen hands/feet
□ Burning sensation after eating
□ Bad breath
□ Large appetite
□ Mouth, canker or cold sores
□ Bleeding, swollen or painful gums
□ Heartburn/belching
□ Stomach pain
□ Vomiting/nausea
□ Diarrhea alternating with constipation
□ Tight/suffocating feeling in chest
□ Bitter taste in mouth
□ Blood shoot eyes/dry eyes
□ Anger easily
□ Skin rashes
□ Headache
□ Numbness of hands and feet
□ Muscle spasms, twitching, cramping
□ Seizures/convulsions
□ Sore, cold or weak knees
□ Low back pain
□ Frequent urination
□ Get up more than once a night to urinate
□ Lack of bladder control
□ Memory problems
□ Hair loss
□ Ringing in ears

Urine is:

□ Normal color □ Clear
□ Dark yellow □ Reddish
□ Cloudy □ Scanty
□ Bad odor □ Burning
□ Painful □ Difficult
□ Urgent

Libido (sex drive) is: □ Normal □ Low □ High

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WOMEN ONLY:

1. Are you pregnant now?
□ Yes □ No

2. Number of children:_____

3. Number of pregnancies:_____

4. Age of first period:_____

5. Age of menopause if applicable:_____

6. Is your menses cycle regular? □ Yes □ No

A. Average number of days in flow:____

B. The flow is:
□ Normal □ Heavy □ Light

C. The color is:
□ red □ dark □ purple
□ light brown □ brown

D. Do you have the following menstruation related symptoms?

□ Blood clots
□ Cramps
□ Nausea
□ Breast distention
□ PMS
□ Bleeding between periods
□ Heavy vaginal discharge between periods

E. Birth control:_____

MEN ONLY:

□ Discharge

□ Pain or swelling of testicles

□ Ejaculatory problems

□ Impotence/erectile dysfunction

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NOTICE OF PRIVACY POLICIES

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law. **We gather personal information and health information in several ways;**

- Information we receive.
- Information we receive from other healthcare providers.
- Information we receive from third party payers. This information is used for treatment, payment and healthcare operations.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose our health infor mation by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminder, by calls, post cards or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

- Upon written request you have the right to access, review or receive copies of your healthcare records.
- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health

  Information.
- You have the right to request that we amend your Protected Health Information; the request must be in writing.
- You have a right to receive all notices in writing. If you have questions, complaints or want more information please contact Chapman Chiropractic Remedy at telephone: (747)245-5421. You may also send a written complaint to: The U.S. Department of Health and Human Services DHHS (Office of Civil Rights)

200 Independence Ave S.W. Room 509 F HHH
Building Washington DC 20201

PATIENT SIGNATURE _____

DATE _____