Pacific Vibes
CHIROPRACTIC | WELLNESS

522 Wilshire Blvd, Ste F
Santa Monica, CA 90401
310-570-2197
pacificvibeschiropractic.com

Practice Member Information:

Name:_____ Date of Birth: _____

Home Address: _____

Phone Number:_____ Email:_____

Marital Status: □Single □Married □Divorced □Widowed □other:_____

Occupation:_____

How did you hear about us?_____

Reason for seeking chiropractic care?_____

Have you previously had chiropractic care? □ yes □ no

Is todays visit a result of a motor vehicle accident? □ yes □ no

Have you had a motor vehicle accident in the past 5 years? □ yes □ no

Are you taking any prescribed or over the counter medications? □ yes □ no If yes, please list:

_____

Are you taking any nutritional supplements? □ yes □ no If yes, please list: _____

_____

Have you ever had any surgeries? □ yes □ no If yes, please list for what and when:_____

_____

Have you ever been hospitalized? □ yes □ no If yes, please list for what and when: _____

_____

Do you consume alcohol? □ yes □ no If yes, how much and how often? _____

Do you smoke cigarettes? □ yes □ no If yes, how much and how often? _____

Do you have a family history of? □ Cancer □ Heart Attack □ Stroke □ Diabetes
□ High Blood Pressure ☐ Autoimmune Disease

Do you work out? □ yes □ no If yes, what kind and how often?_____

How many hours of sleep do you get a night? □ <6 □ 7-9 □ 10+

Are you interested in nutrition and supplements? □ yes □ no

How much water do you drink a day? □ >8 glasses □ <6 glasses □ < 4 glasses

Is there any other important information relating or not relating to today's visit that I should know?_____

What is your level of commitment to your health? (circle one) 1 2 3 4 5 6 7 8 9 10

Family Healthcare Provider: (optional)

Name:_____ Professional Designation:_____

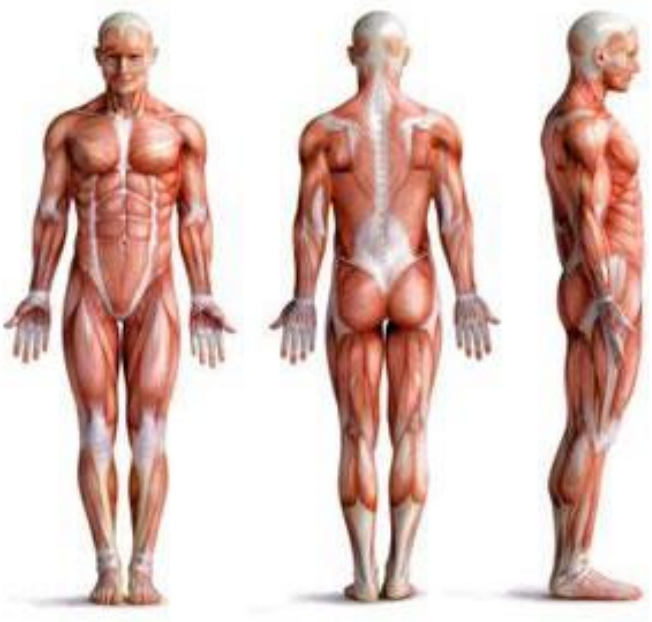
Clinic Name:_____

Additional Healthcare Providers (Neurologist, Endocrinologist, Rheumatologist, Massage Therapist)_____

Today's Complaint:

What brings you in today?_____

_____



- If you are in pain or having symptoms, please **MARK** the exact location on the diagram above. Please describe the **TYPE** of pain: (Sharp, dull, tingling, radiating, throbbing, burning, deep, aching, numbness, stiffness).
- Please describe the **INTENSITY** of your pain: 0-10 (0 being no pain and 10 being on your way to the hospital).

Please describe the **FREQUENCY** of your pain:

☐ Constant, ☐ daily, ☐ weekly, ☐ monthly, ☐ comes and goes.

What makes it feel better? _____

What makes it feel worse? _____

What have you tried that HAS helped? □ ice, □ heat, □ medication, □ massage, □ physical therapy □ chiropractic

What have you tried that HAS NOT helped? □ ice, □ heat, □ medication, □ massage, □ physical therapy, □ chiropractic

Consent:

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered.

I_____hereby consent to receive a chiropractic evaluation including history, neurospinal analysis, examination, and adjustment. Any findings will be communicated before consenting to commencement of care.

_____ _____

Signature of consenting adult *Date*

Energy & Immunity

□ Allergies
□ Anemia
□ Catch colds easily
□ Fatigue (chronic)
□ Thyroid problems

Mind & Emotions

□ Anxiety/Excessive worry
□ Depression/Sadness
□ Insomnia
□ Irritability
□ Mood swings
□ Vivid dreams

Respiratory

□ Asthma
□ Cough
□ Difficulty breathing
□ Shortness of breath
□ Sinus infections
□ Spontaneous sweating
□ Wheezing

Cardiovascular

□ Chest pain
□ Cold hands & feet
□ Low blood pressure
□ Palpitations
□ Rapid heart beat

Ears, Nose, Throat & Eyes

□ Bad taste in mouth
□ Bleeding gums/Mouth sores
□ Blurry vision
□ Cataracts
□ Dry mouth
□ Eye Dryness
□ Excessive phlegm
□ Excessive thirst
□ Fainting
□ Floaters or spots
□ Frequent sore throat
□ Glaucoma
□ Loss of voice
□ Nosebleeds
□ Poor night vision
□ Post-nasal drip
□ Tinnitus□ Swollen glands

Skin

□ Acne
□ Brittle nails
□ Changes in moles/lumps
□ Cysts
□ Dry hair or hair loss
□ Dry, itchy skin
□ Easy bruising
□ Eczema
□ Excessive sweating
□ Hives
□ Night sweats
□ Rashes
□ Psoriasis

Gastro-intestinal

□ Abdominal pain
□ Bad breath
□ Belching
□ Bloating
□ Constipation
□ Diarrhea
□ Excessive hunger
□ Gas
□ Heartburn/Acid reflux
□ Hemorrhoids
□ Hiccups
□ Lack of appetite
□ Laxative use
□ Mucus/Blood in stool
□ Nausea/Vomiting
□ Sudden weight change
□ Ulcers

Neurological

□ Numbness/Tingling
□ Paralysis
□ Poor memory
□ Seizures
□ Tics
□ Tremors
□ Vertigo/Dizziness

Musculoskeletal

□ Arthritis
□ Fibromyalgia
□ Osteoporosis
□ Headaches/migraines
□ Joint pain
□ Muscle cramps
□ Muscle spasms
□ Swelling
□ Tendonitis
□ Weak muscles
□ Neck pain
□ Upper back pain
□ Low back pain
□ Facial pain
□ Pain in legs/feet
□ Pain in arms/hands
□ Rib pain

Kidney/Urinary

□ Burning
□ Edema/Swelling
□ Frequent/Urgent urination
□ Incontinence
□ Kidney stones
□ Painful urination
□ Prone to UTI's

Male Health

□ Decreased libido
□ Discharge from penis
□ Genital itching
□ Groin pain
□ Impotence
□ Premature ejaculation
□ Prostatitis
□ STD_____

Female Health

Age of 1st menses _____
Date of last menses_____
Duration of flow____days
Length of cycle_____days
□ Heavy flow
□ Light flow
□ Irregular cycle
□ Bleeding between periods
□ Clots in menstrual blood
□ Ovulation pain
PMS:
□ Irritability
□ Crying easily
□ Breast tenderness
□ Headaches
□ Low back pain
□ Menstrual cramps

Current form of contraception
_____
For how long _____
# of children born_____
# of miscarriages_____
# of abortions_____
□ Pregnancy complications
Would you like to conceive in the future?
□ yes □ no

□ STD_____
□ Abnormal PAP smear
□ Breast lumps
□ Decreased libido
□ Endometriosis
□ Frequent yeast infections
□ Hot flashes
□ Ovarian cysts
□ PCOS
□ Unusual vaginal discharge
□ Uterine fibroids
□ Vaginal dryness

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Informed Consent to Treatment

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Chiropractic Adjustment.

The primary treatment used by a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures (Please initial next to each area):

Examination Components:

_____Palpation_____Vital signs_____Range of motion testing_____Orthopedic testing

_____Basic neurological testing_____Muscle strength testing_____Postural analysis

_____Nerve testing

Treatment Components:

_____Palpation_____Spinal manipulative therapy (adjustments)

_____Soft tissue/Trigger point therapy_____Myofascial release

Patient should initial each procedure they are consenting to.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, ligament sprain, cervical myelopathy, costovertebral strains and separations, burns or frostbite, worsening/ aggravation of spinal or extremity issues, increased symptoms and pain, and no improvement of symptoms and pain. It has been suggested, that in some rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all part of the body except for those that

control eye movements), and death. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor. I do not expect the doctor to be able to anticipate and explain all the risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

• Self-administered, over-the-counter analgesics and rest
• Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
• Surgery and hospitalization

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Dr. Jacob Maurer, DC to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Jacob Maurer, DC and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date _____

Patient Name _____

Signature _____

Signature of Parent of Guardian

(if a minor)_____

Date_____

Doctors Name _____

Doctors Signature _____

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HIPAA FORM

Our Promise to You:

We want to assure you that we take the Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information.

Why a Privacy Policy?

The most significant variable that has motivated the Federal Government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of the health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within out computers but also with the Internet, phones, fax machines and any device used to copy or transfer this data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We will assure our office adherence to those laws and we want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How your Health information may be used to provide treatment within our office?

Your health information will be used to provide the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all internal office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment:

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in the office. We may do this with insurance forms filed for you by mail or electronically. We will make every effort to work with companies with similar commitment to the security of your health information.

Public Health and National Security:

As permitted or required by State or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friend, and Caregivers:

We may share your health information with those you tell us will be assisting you with your home care, treatment or payment. We will be certain to obtain permission prior to sharing your information. In the event of an emergency, if you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Patients' Rights:

This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Inspect and Copy Your Health Information:

You have the right to read, review, and copy your health information including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge a reasonable fee to supplicate and assemble your copy.

Patient Signature_____

Patient Name _____

Date_____