Health Connection of Tustin
Amy B. Friedman, DC
165 Yorba St
Tustin, CA 92780

New Patient Intake Form

Today's Date (MM/DD/YYY) _____

Whom may we thank for referring you? _____

Patient's First Name _____ Patient's Middle Name _____ Patients Last Name _____

Birth Date (MM/DD/YYY) _____ Social Security Number _____ Age _____

Address _____

City _____ State _____ Zip Code _____ Preferred Language _____

Cell Phone _____ Home Phone _____

Preferred Method of Contact:

O Home Phone O Cell Phone
O Work Phone O E-Mail

E-mail Address _____

Occupation _____ Employer _____ Work Phone _____

Emergency Contact _____ Emergency Contact Phone _____

Primary Care Provider _____ Insurance Carrier _____ Policy Number _____

Patient Name: _____
Date: _____

Dr's Initials: _____

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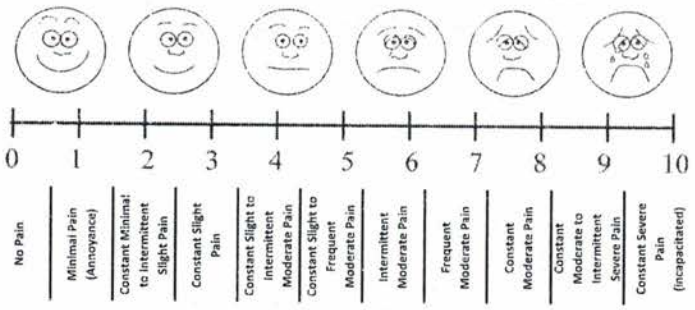
Present Health Concerns



Area of Concern #1 (circle): **Neck** **Mid Back** **Low Back** **Other:**_____

Pain/ Discomfort Scale : 0 1 2 3 4 5 6 7 8 9 10 (please circle)

When did it begin?: _____ How did it begin?: _____

How often do you experience your symptoms?

○ Constantly (76-100% of the time) ○ Occasionally (26-50% of the time) ○ Frequently (51-75% of the time) ○ Intermittently (1-25% of the time)

What aggravates it?_____What alleviates?_____

Limited activities?_____

Area of Concern #2 (circle): **Neck** **Mid Back** **Low Back** **Other:**_____

Pain/ Discomfort Scale : 0 1 2 3 4 5 6 7 8 9 10 (please circle)

When did it begin?: _____ How did it begin?: _____

How often do you experience your symptoms?

○ Constantly (76-100% of the time) ○ Occasionally (26-50% of the time) ○ Frequently (51-75% of the time) ○ Intermittently (1-25% of the time)

What aggravates it?_____What alleviates?_____

Limited activities?_____

Area of Concern #3 (circle): **Neck** **Mid Back** **Low Back** **Other:**_____

Pain/ Discomfort Scale : 0 1 2 3 4 5 6 7 8 9 10 (please circle)

When did it begin?: _____ How did it begin?: _____

How often do you experience your symptoms?

○ Constantly (76-100% of the time) ○ Occasionally (26-50% of the time) ○ Frequently (51-75% of the time) ○ Intermittently (1-25% of the time)

What aggravates it?_____What alleviates?_____

Limited activities?_____

Have you previously seen a Chiropractor? ○ Yes ○ No

If so, when was your last visit? _____

When was the last time you had X-rays?_____ MRI?_____ Where?_____

Approximately when was your last medical physical?_____

Other health care professional's you've consulted for the same issues?_____

If so, when was your last visit? _____

Patient Name:_____

Date:_____

Dr's Initials:_____

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Health History

Had	Have		Had	Have		Had	Have	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Angina	O	O	Smoking/Tobacoo Use
O	O	Low Back Pain	O	O	Kidney Stones	O	O	Drug/Alcohol Dependence
O	O	Shoulder Pain	O	O	Kidney Disorders	O	O	Allergies
O	O	Elbow/Upper Arm Pain	O	O	Bladder Infection	O	O	Depression
O	O	Wrist Pain	O	O	Painful Urination	O	O	Systemic Lupus
O	O	Hand Pain	O	O	Loss of Bladder Control	O	O	Epilepsy
O	O	Hip Pain	O	O	Weight Gain/Loss	O	O	Dermatitis/Eczema
O	O	Upper Leg Pain	O	O	Loss of Appetite	O	O	HIV/AIDS
O	O	Knee Pain	O	O	Abdominal Pain	**For Females Only**		
O	O	Ankle/Foot Pain	O	O	Ulcer	O	O	PMS
O	O	Jaw Pain	O	O	Hepatitis	O	O	Birth Control Pills
O	O	Joint Pain/ Stiffness	O	O	Liver/Gall Bladder Probler	O	O	Hormonal Replacement
O	O	Arthritis	O	O	General Fatigue	O	O	Pregnancy
O	O	Rheumatoid Arthritis	O	O	Uncoordinated Movemen	If Yes, When:_____		
O	O	Cancer (Type/Date) _____	O	O	Visual Disturbances	**For Males Only**		
O	O	Tumor	O	O	Dizziness	O	O	Prostate Problems
O	O	Asthma	O	O	Glaucoma	O	O	Loss of Muscle
O	O	Chronic Sinusitis	O	O	Stroke	O	O	Erectile Dysfunction
O	O	Other:_____						

Family Health History: (Cancer, Arthristis, Diabetes, Heart Disease, Kidney Disease, Etc)

_____

List ALL surgical procedures or hospitalizations that you have had or are considering:

_____

List ALL prescription medication/ over-the-counter medications that you are currently taking:

_____

Pain Relievers **O Daily** **O Weekly** **O Occasionally** **O Never**

Physical Activity Level: **O Sedentary** **O Mildly Active** **O Moderately Active** **O Extremely Active**

Sleep Habits: **O Back** **O Side** **O Stomach** **Hours per night:**_____

Social History and Health Habits:

Alcohol	O Daily	O Weekly	O Occasionally	O Never
Energy Products	O Daily	O Weekly	O Occasionally	O Never
Soft Drinks	O Daily	O Weekly	O Occasionally	O Never
Water	O Daily	O Weekly	O Occasionally	O Never
Caffeine	O Daily	O Weekly	O Occasionally	O Never
Drugs	O Daily	O Weekly	O Occasionally	O Never
Tobacco	O Daily	O Weekly	O Occasionally	O Never

Patient Name:_____

Date:_____ Dr's Initials:_____

WORK / COMP HISTORY

Patient _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Name of Compensation Carrier: _____ Phone ( ) _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone ( ) _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____
2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? ( ) Yes ( ) No
3. Previous Workers' Compensation Injury? ( ) Yes ( ) No
4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to _____
5. Injured at: _____ City _____ State _____ Zip _____
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____

   _____
8. In your own words, please describe accident: _____

   _____

   _____

   _____
9. Have you been treated by another doctor for this accident? ( ) Yes ( ) No

   If yes, please list doctor's name and address: _____

   _____

   What type of treatment did you receive? _____

   How long were you treated by this doctor? _____
10. Are you: ( ) improved ( ) unchanged ( ) getting worse
11. What types of medicines are you taking? _____

    _____

    Do these medicines help? ( ) Yes ( ) No ( ) Don't know
12. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?

    ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week

    ( ) Monthly ( ) Other _____

    Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

    ( ) Yes ( ) No ( ) Don't know

    If yes, describe: _____

    _____

    _____

    Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

    Please provide details of accident(s): _____

    _____

    _____

14. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

    Describe: _____

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

    Describe: _____

    _____

    _____

16. Have you had any surgeries? ( ) Yes ( ) No

    If yes, list type of surgery and date: _____

    _____

    _____

17. Have you had any nervous or mental illnesses? ( ) Yes ( ) No

    Have you had psychiatric care? ( ) Yes ( ) No

18. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

19. Have you returned to work since this accident? ( ) Yes ( ) No

    If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back
2. My pain began: ( ) gradually ( ) suddenly
3. I have pain: ( ) sometimes ( ) all of the time
4. My pain goes into my: ( ) right leg ( ) left leg ( ) both
5. I have tingling and/or numbness in my: ( ) right leg ( ) left leg ( ) both
6. My pain is worse when I:
   - cough or sneeze ( ) Yes ( ) No
   - sit ( ) Yes ( ) No
   - bend ( ) Yes ( ) No
   - walk ( ) Yes ( ) No
   - lift ( ) Yes ( ) No
   - push ( ) Yes ( ) No
   - pull ( ) Yes ( ) No
7. My back is worse with sexual activity ( ) Yes ( ) No
8. My pain wakes me up during the night ( ) Yes ( ) No
9. Changes in the weather affect my pain ( ) Yes ( ) No

NECK PAIN:

1. My neck pain began: ( ) gradually ( ) suddenly
2. I have pain: ( ) sometimes ( ) all of the time
3. My pain goes into my: ( ) right arm ( ) left arm ( ) both
4. I have tingling and/or numbness in my: ( ) right arm ( ) left arm ( ) both
5. My pain is worse when I:
   - cough or sneeze ( ) Yes ( ) No
   - bend forward ( ) Yes ( ) No
   - lift ( ) Yes ( ) No
   - push ( ) Yes ( ) No
   - pull ( ) Yes ( ) No
   - turn my head ( ) Yes ( ) No
6. My pain wakes me up during the night ( ) Yes ( ) No
7. Changes in the weather affect my pain ( ) Yes ( ) No
8. I have neck stiffness ( ) Yes ( ) No
9. I have headaches ( ) Yes ( ) No
10. If I do get headaches, they occur: ( ) sometimes ( ) all of the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____

_____

_____

_____

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING		FIRM GRASPING		FINE MANIPULATING	
Right hand	( ) Yes	( ) No	( ) Yes	( ) No	( ) Yes	( ) No
Left hand	( ) Yes	( ) No	( ) Yes	( ) No	( ) Yes	( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No

Describe: _____

_____

_____

8. Are you required to be around moving machinery? ( ) Yes ( ) No

Describe: _____

_____

_____

9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No

Describe: _____

_____

_____

10. Are you required to drive automotive equipment? ( ) Yes ( ) No

Describe: _____

_____

_____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No

Describe: _____

_____

_____

12. Please list any additional comments: _____

_____

_____

Signature: _____ Date: _____

Informed Consent for Chiropractic Manipulation and Treatment

As with any healthcare procedure there are certain complications which may arise during the course of chiropractic manipulation and ancillary therapy such as hot or cold packs, electric muscle stimulation, laser therapy, micro-stimulation, traction, therapeutic ultrasound, and non-surgical spinal decompression. Dr. Friedman is required to advise her patients that there are risks associated with such treatments.

The nature of chiropractic treatment: The doctor will use her hands or a mechanical device (known as an Activator instrument) to move your joints, known as chiropractic manipulation. With manual adjustments you may feel a "click or "pop", such as the noise when a knuckle is "cracked". You may or may not feel movement of the joint. Some patients may experience soreness/tenderness/stiffness following the first few days of treatment which are more common when beginning care vs. ongoing treatment.

Possible Risks: Complications may include fractures of the bone, muscular strain, ligamentous sprain, dislocations of the joints, or injury to intervertebral discs, nerves, or spinal cord. An exceptionally rare cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck or more rarely dislodged if you are predisposed to blood clots. Ancillary therapeutic procedures could produce skin irritation, bruising, burns or minor abrasions.

Probability of risks occurring: The risks of complications due to chiropractic treatment (manipulation and ancillary procedures) have been described as "rare". The risk of cerebrovascular injury or stroke has been estimated at one to one in twenty million and can be even further reduced by screening procedures. The doctor will make every appropriate effort to screen for contraindications to care; however, I know it is my responsibility to inform the doctor of any conditions that are not obvious from my intake forms or physical findings upon my examination. Significant high blood pressure and A-Fib already predispose patients to stroke, regardless of manipulation. Underlying diseases such as cancer or osteoporosis could lead to more risk of fractures.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risk of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as and extended convalescent period in a significant number of cases.

Risk of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I understand that the doctor will verbally acknowledge any unusual risks I may pose to manipulation.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I consent to undergo the recommended treatment as recommended by the doctor, including spinal manipulation, and hereby give my full consent to treatment. I intend this consent to apply to all my present and future chiropractic care.

Signature	Printed Name	Date

OFFICE POLICY FOR HEALTH CONNECTION OF TUSTIN

Financial Responsibility: You are ultimately responsible for charges incurred as a result of any chiropractic evaluation, treatment or supplies provided for your care regardless of expected payment by your insurance company or third party. If you have chiropractic benefits through your private health insurance, we will verify your coverage and based upon that information notify you of your responsibility, which is never a guarantee until your insurance is billed and an EOB (explanation of benefits) is received. Insurance billing is provided for ABFCC (Amy B Friedman Chiropractic Corporation) through Priority One Billing who often utilizes online statements and payment portals sent through our practice management software, Kareo. If you have a flat co-pay, you are responsible for payment each day you receive care. Co-insurance and deductible fees that are applied by PPO insurances will be balance billed and due within thirty days of upon receipt of your email or if preferred paper/mailed statement.

- Personal Injury Claims: are taken upon approval and arrangements will be made on an individual basis. If you have MedPay (Medical coverage) on ***your*** auto policy it is customary for our office to bill that policy during the course of your care regardless if the injury is the fault of a third party. Third party cases without an attorney require the patient to pay a portion of their total bill as they receive care (see third party agreement) and the balance upon settlement of the case. If you have an attorney representing your case, a lien may be signed upon approval of the office. You are ultimately responsible for paying your balance in full immediately upon settlement from a third party.
- Work Related Injury Cases: are taken upon approval and require pre-authorization.
- Massage Therapy: All massage therapy services are provided on a fee-for-service/cash basis and require payment upon completion of that service. In order to hold a future massage appointment a credit card will be kept on file and only charged for late cancellations or missed appointments. Missed or cancelled massages less than 24-hour notice are subject to fees as determined by our massage policy, $35 for ½ hour and $65 for one hour.
- Supplements and Supplies: Any supplements or supplies must be paid upon receipt.
- All accounts over 60 days are considered overdue and subject to collections.

Informed Consent: By signing below, I acknowledge I have read and received the informed consent for chiropractic care and have all my questions answered regarding the safety and purpose of chiropractic manipulative treatment. I wish to rely on the doctor's experience and expertise to exercise good judgement when choosing the most safe and effective course of care based upon my history, physical exam and any radiological imaging obtained. I consent for care for the entire course of treatment for my present and future conditions.

Authorization and Assignment: I authorize Health Connection of Tustin to release any information and records required and appropriate for appropriate insurance authorization, billing or appeals, attorney, or referred physician. I authorize direct payment from my insurance company or attorney to my doctor for charges made for treatment rendered. This authorization and assignment are irrevocable and ongoing until all monies owed have been satisfied and paid in full. It will remain in continual effect. A photocopy shall be as valid as the original document.

I acknowledge that I have read and understand the Health Connection of Tustin office policy regarding my financial responsibility, informed consent and assignment of payment for services rendered.

_____ _____ _____

Printed Name Signature of patient if >18 yrs or parent Date

_____

Name of parent or legal guardian

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You may request to see the notice at any time. You ascertain that by your signature, that you have review our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call, e-mail, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the allowed members:

_____

_____

This consent was signed by:_____
(Print Name Please)

Signature:_____ Date:_____

Office Staff: _____ Date:_____