



## New Patient Information

Date: \_\_\_/\_\_\_/\_\_\_

Welcome! Please allow our staff to photocopy your insurance card (if applicable)

### PLEASE PRINT CLEARLY

Full Name: \_\_\_\_\_ Gender: M F Age: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers License #: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Marital Status: S M D W # of Children: \_\_\_\_\_ Work Status: Full-time Part-time Retired

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Females:** Last Menstrual Period: \_\_\_\_\_ Pregnant? Y N Nursing? Y N

Name of Spouse, Parent or Guardian: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

In Case of an Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

How did you hear about our clinic? Who may we thank for referring you? \_\_\_\_\_

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow SOL Santa Cruz to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy. We have taken all precautions that are known by SOL Santa Cruz to assure that your records are not readily available to those who don't need them.
6. Patients have the right to file a formal complaint about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

**Patients Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Spouse's or Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**HEALTH CONCERNS:** Please list your top health concerns in order of priority

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

**TREATMENT:** What type of treatment are you looking for?

- I am looking for the most minimal amount of care to “patch up the symptoms” of my problem.
- I am looking to resolve my symptoms and then go on to “fix the cause” of my problem.
- I am looking to take care of my problem and then go on to “achieve optimal health and wellness”

**COMPLAINT/PROBLEM: In relation to your primary complaint:**

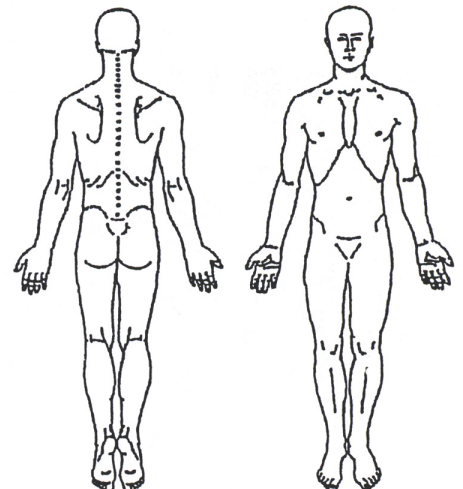
When did you first seek treatment for this problem? \_\_\_\_\_ Has another doctor(s) treated you for this condition: Y N  
 If yes, whom? \_\_\_\_\_ Treatment(s): \_\_\_\_\_  
 Have you had any intolerance or reactions to treatments? Y N Describe: \_\_\_\_\_  
 Is this a recurrence, when was the first time you noticed this problem? \_\_\_\_\_  
 How did it originally occur? \_\_\_\_\_ Has it become worse recently? Y N describe: \_\_\_\_\_  
 How frequent is the condition? Constant Daily Intermittent Night Only.  
 How long does it last? All day Few hours Minutes  
 Is this condition interfering with your : Work Sleep Daily routine Recreation Other: \_\_\_\_\_  
 How long has it been since you really felt good? Days Weeks Months Years  > 10 years  
 Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other  
 Is there anything that you can do to relieve the problem? Y N If yes, describe: \_\_\_\_\_  
 If no, what have you tried to do that has no helped? \_\_\_\_\_  
 What do you believe is wrong with you? \_\_\_\_\_  
 Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? \_\_\_\_\_  
 Have you been in an auto accident?  Past year  Past 5 years Over 5 years Never  
 Describe: \_\_\_\_\_

**Please check all of the symptoms that apply. (P=Past / C=Current)**

- | P/C  | P/C   | P/C   |
|--|---|---|
| <input type="checkbox"/> Headache            | <input type="checkbox"/> Sweating             | <input type="checkbox"/> Fatigue                  |
| <input type="checkbox"/> Facial pain         | <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Menstrual irregularities |
| <input type="checkbox"/> Eye pain            | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Elbow/ Hand Pain         |
| <input type="checkbox"/> Blurred vision      | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Tingling in Hands        |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Abdominal Pain       | <input type="checkbox"/> Clammy Hands             |
| <input type="checkbox"/> Earache             | <input type="checkbox"/> Nausea/ vomiting     | <input type="checkbox"/> Low Back Pain            |
| <input type="checkbox"/> Forgetfulness       | <input type="checkbox"/> Poor Appetite        | <input type="checkbox"/> Hip Pain                 |
| <input type="checkbox"/> Confusion           | <input type="checkbox"/> Fullness of Bladder  | <input type="checkbox"/> Knee Pain                |
| <input type="checkbox"/> Sinusitis           | <input type="checkbox"/> Urination Difficulty | <input type="checkbox"/> Poor Circulation         |
| <input type="checkbox"/> Teeth Grinding      | <input type="checkbox"/> Frequent Urination   | <input type="checkbox"/> Swollen Joints           |
| <input type="checkbox"/> Dry mouth           | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Joint Stiffness          |
| <input type="checkbox"/> Excessive Thirst    | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Swollen Ankles           |
| <input type="checkbox"/> Unpleasant Taste    | <input type="checkbox"/> Decreased Sex Drive  | <input type="checkbox"/> Ankle/foot Pain          |
| <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Shoulder Pain        | <input type="checkbox"/> Tingling in Feet         |
| <input type="checkbox"/> Persistent Coughing | <input type="checkbox"/> Swallowing Pain      | <input type="checkbox"/> Walking Problems         |
| <input type="checkbox"/> Unsteady Voice      | <input type="checkbox"/> Lump in Throat       | <input type="checkbox"/> Sore muscles             |
| <input type="checkbox"/> Chest Pressure      | <input type="checkbox"/> Sore Throat          | <input type="checkbox"/> Weak Muscles             |
| <input type="checkbox"/> Slow Heart Rate     | <input type="checkbox"/> Convulsions          | <input type="checkbox"/> Paralysis                |
| <input type="checkbox"/> Rapid Heart Rate    | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Shaking                  |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Impatience           | <input type="checkbox"/> Feel Loss of Control     |
| <input type="checkbox"/> Other _____         |   |   |

**Please use the legend symbols below to accurately mark the areas in which you Feel these sensations**

Stabbing/Cutting -///      Tingling - T  
 Burning - XXX              Cramping - C  
 Numbness - ~ ~              Dull - ###





**ALLERGIES:** Please check and list all allergies.

- Food: \_\_\_\_\_
- Medications: \_\_\_\_\_
- Seasonal / Other: \_\_\_\_\_

**MEDICATIONS:** Please check and list all medications that you are currently taking with the date you began taking them.

	<u>Medication Name</u>	<u>Date started</u>
<input type="checkbox"/> Antacids		
<input type="checkbox"/> Antibiotics		
<input type="checkbox"/> Antidepressants		
<input type="checkbox"/> Anti-Diabetics		
<input type="checkbox"/> Anti-Inflammatory		
<input type="checkbox"/> Blood Pressure Lowering Meds.		
<input type="checkbox"/> Cholesterol Lowering Meds.		
<input type="checkbox"/> Hormone replacements (HRT)		
<input type="checkbox"/> Oral Contraceptives		
<input type="checkbox"/> Other		

**SCARS / SURGICAL PROCEDURES:** List all scars and surgical procedures you have had.

\_\_\_\_\_

\_\_\_\_\_

**SUPPLEMENTS:** Do you take Vitamins/Supplements or Herbs? Y N If yes, who recommended them? \_\_\_\_\_

<u>HABITS:</u>	Heavy	Moderate	Light	None	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Exercise</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8+ hrs	7-8hrs	6-7 hrs	5-6hrs	<5hrs	
Soda / Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Sleep</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5+	4	3	2		
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Meals/day</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64+oz	32-64 oz	16-32 oz	<8 oz		
					<u>Water/day</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**WORK ACTIVITY:**  Heavy Labor  Light Labor  Mostly sitting  Mostly standing  Walking / Moving  Driving

**FAMILY HISTORY:** Identify any conditions that you, or any of your family members have now or have had in the past:

(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

- |                          |                   |                     |                  |
|--------------------------|-------------------|---------------------|------------------|
| ___ Alcoholism           | ___ Eczema        | ___ Miscarriage(s)  | ___ Tumor(s)     |
| ___ Anemia               | ___ Emphysema     | ___ Mumps           | ___ Ulcer(s)     |
| ___ Cancer               | ___ Epilepsy      | ___ Pleurisy        | ___ Other: _____ |
| ___ Cold sores           | ___ Goiter        | ___ Pneumonia       | _____            |
| ___ Deep Vein Thrombosis | ___ Gout          | ___ Polio           | _____            |
| ___ Detached retina      | ___ Heart disease | ___ Rheumatic fever | _____            |
| ___ Diabetes             | ___ HIV/AIDS      | ___ Stroke          |                  |

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
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.



Karen K. Roitz, D.C., C.C.S.P.  
Jamie L. Bjerkhoel, D.C.  
1510 Seabright Avenue  
Santa Cruz, CA 95062

**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



## Financial Policies & Agreement

### Cash or Insurance patients

We would like to take a moment to welcome you to our office and familiarize you with our financial policy.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors recommendations. A complete list of services is available at the front desk.

As a courtesy, our office will bill your insurance company for you. Within the first week of treatment we will verify your insurance benefits. In the interim you will be responsible for 20% of the charges due. Any credit or balance will be determined after payment is received from your insurance company. The verification is only an estimated summary of benefits provided by your insurance company and does not guarantee payment. **We will only bill your insurance; we do not provide collection services.**

You are responsible for payment of any deductibles, co-payments, and/or patient portions at the time services are rendered. If your insurance company does not pay within 60 days from the dated billed, you will be responsible for payment in full at that time. If your account becomes grossly past due (120 days) there will be a *20% annual interest rate charge, which will accrue on a monthly basis until the balance is paid in full.*

As a courtesy, our office will notify you the day before your scheduled appointment to remind you of the time and type of appointment scheduled. If you cancel your appointment with less than 24 hours notice, or do not show up for any scheduled appointment you will be billed for the doctor's time (\$35.00 for every standard (15 minute) office visit or \$45.00 for massage).

My signature denotes that I have read, understand and agree to the above.

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Patient or guardian signature

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Date



## HIPAA REGULATIONS

### Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### Our Legal Duty

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices. This is listed on our Web site: [www.solsantacruz.com](http://www.solsantacruz.com).

### Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

**Treatment:** We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to *your* other health care providers to assist them in treating you.

**Payment:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any question about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

*Your signature below indicates your understanding and compliance of the above privacy practices.*

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature