PATIENT INTRODUCTION FORM

Today's Date: _____

Last Name: **MI:** **First Name:**	
Home Address: **City:** **State:** **Zip:**	
Date Birth: Age:	Telephone: Home: Office:
Height: Weight:	Who Referred You to Our Office:
Employer's Name:	Marital Status (Circle): Single, Married, Divorced, Widowed
Occupation:	Name of Family Physician:

Email Address:

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws. Patient confidentiality and privacy/security applies to any **protected health information (PHI).** Signature: _____Date:_____ Expiration Date/Event for Authorization: ☐ No expiration date ☐When treatment has concluded and bills have been paid. ☐ Date: _____	**PRIVACY NOTICE-HIPAA.** I acknowledge that the office, has presented me with a copy of the privacy practices and I have been able to read the practice policies notice that is posted on the waiting room wall. This notice explains how my protected health information (PHI) may be used and what the office responsibilities are regarding my privacy rights. I have been allowed to request a printed sheet of the office's privacy notice. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

IS THIS VISIT RELATED TO:

☐ Work Related Injury/Symptoms	☐ Motorcycle-Bicycle Injury	☐ Non-Injury Pain/Symptoms
☐ Sport or Recreational Injury	☐ Home Injury Symptoms	☐ Check-up Only
☐ Motor Vehicle Crash Injury	☐ School/Employment Physical	☐ Other (Describe):

HEALTH-MEDICAL INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	☐ Yes, ☐ No If yes, we need a copy of the card
If yes, indicate Insurance Company Name (Need copy of card).	Insurance Name: _____ Address: _____ Telephone: _____
Are you the insured person or dependent (wife/husband/child)?	☐ Insured, ☐ Dependent
If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number, and the company/business name of the insured employer in order to do billing.	Name of Insured Person: _____ Social Security Number: _____ Insured Date of Birth: _____ Name of Insured Employer:_____
What is your co-payment amount for each visit?	Amount: $ Percentage: %
Do you have a health insurance deductible for chiropractic?	☐ Yes, ☐ No Deductible $ _____ Have you met deductible yet?
Specific chiropractic health insurance benefits	Number visits per year #_____. Amount per year: $_____

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES FOR AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS.

Patient Signature and Date	I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health/automobile insurance carrier. Minors must have parent's signature.

Doctor's Name/Address: Dr. Dhesi, FCG Healthcare, 1081 Market Place, Suite 100, San Ramon, CA 94583

GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	History of poor healing or told that you have a healing disorder?	☐	☐
☐	Smoke cigarettes or use tobacco products?	☐	☐
☐	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	☐	☐
☐	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	History of any disease such as AIDS, Tuberculosis, ALS, Meningitis, etc.?	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	☐	☐
☐	Epilepsy-Seizure-Convulsion history or any other neurological disease?	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	☐	☐
☐	Cancer history or cancer treatment or surgery of any type?	☐	☐
☐	Stroke history (Indicate any suspected mild strokes or transient ischemic attacks)?	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration in the spine?	☐	☐
☐	Have you ever been hospitalized? Why/When:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	☐	☐
☐	Hypertension or high blood pressure? If yes, name of MD seeing:	☐	☐
☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis?	☐	☐
☐	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?	☐	☐
☐	Autoimmune disease, Crohn's disease, ulcerative colitis, muscle diseases, etc?	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

(☐ I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Home/Sports Injury	☐ Lifting Injury	☐ Car Accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches	☐ Neck Pain	☐ Middle Back Pain	☐ Low Back Pain	☐ Shoulder Pain
☐ arm numb/tingling	☐ Arm Pain	☐ Leg Pain/Tingling	☐ Other Pain:	

FRACTURES/BROKEN BONES HISTORY

(☐ I have never had any broken bones). If you have broken/fractured any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone, ribs, or sternum		☐ Pelvis or hip bones	
☐ Arm, leg, hand, or foot bones		☐ Other: List	

PREVIOUS SURGERIES

(☐ I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Abdominal/chest Surgery or Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Liver/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Head/Brain/Spinal Cord/Nerve		☐ Hernia (inguinal or hiatal)	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

When did you have your last physical examination by a medical doctor? Year: _____ Name MD: _____

Patient Name:	Doctor's Name:

FCG HEALTHCARE, 1081 MARKET PLACE, SUITE 100, SAN RAMON, CA 94583 [925]275-9350

GENERAL HEALTH HISTORY (Page 2)

☐ No, ☐ Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, spinal cord, brain, nerves, or other diseases? If yes, please describe:____

_____

☐ No, ☐ Yes **Have you ever been to a Chiropractor before for any condition?**
If yes, Chiropractor's Name/City : _____ Year:_____
List Problem(s) that the Chiropractor treated you for:_____

☐ No, ☐ Yes **Do you have any problems laying face down on an examination table**, including tender chest/breast, level of pain, etc? If yes, why: _____

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Other:	

Did your current symptoms come on? ☐ Suddenly, ☐ Gradually

ARE YOU TAKING ANY MEDICATIONS PRESENTLY?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Blood pressure or Stroke prevention medications	☐ Endocrine-Hormone medications
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:
☐ Diabetic medications	☐ Immunity drugs	☐ Other:

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

☐ Morning is when pain is worse	☐ Bending your back increases pain	☐ Walking increases pain
☐ Afternoon/evening pain worse	☐ Lying down flat increases pain	☐ Standing increases pain
☐ During sleep hours pain worse	☐ Sitting increases pain	☐ Exercise/Stretching increases pain
☐ Standing up from sitting	☐ Poor posture increases pain	☐ Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

☐ Walking	☐ Being flat on your back	☐ Exercise/Stretching
☐ Sitting	☐ Standing	☐ Other:

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

Patient Name:	Doctor's Name:

Form 1010

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, numbness or previous severe injury or recent accident.*

Other options for the treatment of pain include: *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, and/or surgery*. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above-specified complicating factors and all other conditions that have caused me pain in the past.

_____	_____	_____
Patient Name	**Signature**	**Date**
_____	_____	_____
Witness Name	**Signature**	**Date**