PATIENT:	CHART NUMBER:	DATE:

Welcome to Lee Chiropractic

PLEASE TELL US ABOUT YOURSELF

Name: (last)_____(first)_____(mi)_____

Home Address: (st)_____(city)_____(state)_____(zip)_____

Phones: (home)_____(cell)_____Email:_____

Gender Preference: Male ☐ Female ☐ FTM ☐ MTF ☐ Gender Fluid/Queer ☐ Decline to State ☐ Other ☐ _____

Birthdate:_____Age:_____Social Security (optional):_____

Employer Name: _____Occupation:_____

Work Address:_____Work Phone:_____ext_____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other ☐ _____

Do you have children? Yes☐ No ☐ Ages (If applicable):_____

Emergency Contact:_____Phone:_____Relationship: _____

Person responsible for this account: _____

Who may we thank for referring you to our office? _____

What is the reason for your visit? _____

Have you ever seen a chiropractor before? Yes ☐ No ☐ If yes what was their name? _____

Office Address: _____ Phone Number: _____

Have you gotten XRAYS, MRIs, or CT Scans in the last five years? Yes ☐ No ☐

Have you gotten in any auto accidents in the last five years? Yes ☐ No ☐ If yes, please explain: _____

_____

Have you had any serious falls or injuries in the last five years? Yes ☐ No ☐ If yes, please explain: _____

_____

Are you seeing any other doctor or therapist for pain or injury-related issues? Yes ☐ No ☐ If yes, please list below:

Date	Name	Treatment/Tests	Improved?
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐

PLEASE READ AND SIGN BELOW

I understand and agree that all payments are due at the time services are rendered. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees required to effect collection s allowed by law. I also understand that any billings to my insurance carrier will be done directly by me and any payments received by the insurance carriers owed directly back to me from the carrier.

_____

Print Name

_____ _____

Responsible Party's Signature Date

PATIENT: CHART NUMBER: DATE:

Symptom Survey

GENERAL SYMPTOMS:

☐ Nervousness ☐ Irritability ☐ Fatigue ☐ PMS
☐ Depression ☐ Sleep Loss ☐ Tension ☐ Jaw Pain

HEADACHES:

How often: (#) _____ times per ☐ Day ☐ Week ☐ Month
☐ Mild ☐ Moderate ☐ Severe
☐ Sharp ☐ Dull ☐ Throbbing ☐ Steady Aches
☐ Forehead ☐ Temples ☐ Back of Head ☐ Behind eyes
☐ Light headed ☐ Memory Loss ☐ Ringing in Ears
☐ Hearing Loss ☐ Blurred Vision ☐ Loss of Balance
☐ Double Vision ☐ Loss of Taste ☐ Sensitivity to light

NECK:

How often: (#) _____ times per ☐ Day ☐ Week ☐ Month
☐ Mild ☐ Moderate ☐ Severe
☐ Stiffness ☐ Muscle Spasm ☐ Grinding/Grating Sounds
☐ Left Side ☐ Right Side ☐ Upper ☐ Lower
☐ Forward ☐ Backward ☐ Left ☐ Right

SHOULDERS:

How often: (#) _____ times per ☐ Day ☐ Week ☐ Month
☐ Mild ☐ Moderate ☐ Severe
A) Pain in Joint: ☐ Left ☐ Right ☐ Both
B) Pain across shoulders: ☐ Left ☐ Right ☐ Both
C) Limited Movement: ☐ Left ☐ Right ☐ Both
D) Tension: ☐ Left ☐ Right ☐ Both

ARMS:

How often: (#) _____ times per ☐ Day ☐ Week ☐ Month
☐ Mild ☐ Moderate ☐ Severe
1. Upper: ☐ Left ☐ Right ☐ Both
2. Elbow Pain: ☐ Left ☐ Right ☐ Both
3. Forearm Pain: ☐ Left ☐ Right ☐ Both
4. Upper arm pins/needles: ☐ Left ☐ Right ☐ Both
6. Forearm pins/needles: ☐ Left ☐ Right ☐ Both
7. Upper arm numbness: ☐ Left ☐ Right ☐ Both
8. Forearm numbness: ☐ Left ☐ Right ☐ Both
9. Radiating arm pain: ☐ Left ☐ Right ☐ Both

HANDS:

How often: (#) _____ times per ☐ Day ☐ Week ☐ Month
☐ Mild ☐ Moderate ☐ Severe
1. Wrist Pain ☐ Left ☐ Right ☐ Both
2. Hand pain: ☐ Left ☐ Right ☐ Both
3. Numbness: ☐ Left ☐ Right ☐ Both
4. Tingling ☐ Left ☐ Right ☐ Both

MID-BACK:

How often: (#) _____ times per ☐ Day ☐ Week ☐ Month
☐ Mild ☐ Moderate ☐ Severe
A) Pain: ☐ Left ☐ Right ☐ Both
B) Pain Level: ☐ Mild ☐ Moderate ☐ Severe
C) Pain type: ☐ Sharp/Stabbing ☐ Dull ache
D) Muscle Spasms: ☐ Left ☐ Right ☐ Both

CHEST:

How often: (#) _____ times per ☐ Day ☐ Week ☐ Month
☐ Mild ☐ Moderate ☐ Severe ☐ Shortness of Breath
☐ Deep chest pain: ☐ Left ☐ Right ☐ Upper ☐ Lower
☐ Rib Pain: ☐ Left ☐ Right ☐ Both ☐ Irregular heartbeat

ABDOMINAL SYMPTOMS:

How often: (#) _____ times per ☐ Day ☐ Week ☐ Month
☐ Mild ☐ Moderate ☐ Severe
☐ Left ☐ Right ☐ Upper ☐ Lower ☐ Constipation
☐ Nervous Stomach ☐ Nausea ☐ Gas ☐ Diarrhea ☐ Heartburn

LOW-BACK:

How often: (#) _____ times per ☐ Day ☐ Week ☐ Month
☐ Mild ☐ Moderate ☐ Severe
1. Upper lumbar pain: ☐ Left ☐ Right ☐ Both
2. Lower lumbar pain: ☐ Left ☐ Right ☐ Both
3. Sacroiliac (buttocks) pain: ☐ Left ☐ Right ☐ Both
4. Muscle Spasm: ☐ Left ☐ Right ☐ Both
5. Radiating pain to: ☐ Foot ☐ Knee ☐ Hip/Buttock

HIPS AND LEGS:

1. Buttock Pain: ☐ Left ☐ Right ☐ Both
B) Hip Joint Pain: ☐ Left ☐ Right ☐ Both
C) Pain Down Leg: ☐ Left ☐ Right ☐ Both
Location: ☐ Front ☐ Back ☐ Side
Radiates To: ☐ Knee ☐ Calf ☐ Foot
D) Numbness down Leg: ☐ Left ☐ Right ☐ Both
Location: ☐ Front ☐ Back ☐ Side
E) Pins & Needles: ☐ Left ☐ Right ☐ Both
Location: ☐ Front ☐ Back ☐ Side
F) Knee Pain: ☐ Left ☐ Right ☐ Both

FEET

A) Ankle Pain: ☐ Left ☐ Right ☐ Both
B) Swollen ankle: ☐ Left ☐ Right ☐ Both
C) Foot Pain: ☐ Left ☐ Right ☐ Both
D) Foot numbness: ☐ Left ☐ Right ☐ Both
E) Swollen Feet: ☐ Left ☐ Right ☐ Both

PATIENT:	CHART NUMBER:	DATE:

Lee Chiropractic
Confidential Patient Case History

HISTORY OF CHIEF COMPLAINT:

What is the reason for your visit?_____

When did it begin?_____

How did it begin?

Automobile accident? Yes ☐ No ☐ Date of injury _____

Employment? Yes ☐ No ☐ Date of injury _____

Fall? Yes ☐ No ☐ Date of injury _____

Other_____

What makes it better? (Please check all that apply)

☐ Sitting ☐ Standing ☐ Resting ☐ Walking ☐ Bending ☐ Medication:

☐ Ice ☐ Heat ☐ Stretching ☐ Massage ☐ Exercise ☐ Other:

What makes it worse? (Please check all that apply)

☐ Sitting ☐ Standing ☐ Resting ☐ Walking ☐ Bending ☐ Medication:

☐ Ice ☐ Heat ☐ Stretching ☐ Massage ☐ Exercise ☐ Other:

Describe the pain: (Please check all that apply)

☐ Cramp ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Dull Ache

☐ Muscular ☐ Burning ☐ Bruised ☐ Numbness ☐ Deep Pain ☐ Heaviness

☐ Other (please explain): _____

Does the pain radiate? Yes ☐ No ☐ If yes, how far?_____

How frequently do you feel the pain? Always ☐ Sometimes ☐ Often ☐ Infrequently ☐ Almost Never ☐

On a scale of 0 (none) to 10 (worse pain ever): How bad is the pain at its worse? _____ How bad is the pain at its best? _____

When is your pain most severe? ☐ Morning ☐ Afternoon ☐ Evening ☐ Sleeping ☐ Constant

Do you wake with pain the morning? Yes ☐ No ☐ Does it alleviate with movement? Yes ☐ No ☐

Does your pain wake you up at night? Yes ☐ No ☐ Does it keep you up at night? Yes ☐ No ☐

CURRENT WORK STATUS (Please check all that apply):

☐ Regular Duty ☐ Regular duty with pain and mobility issues

☐ Light/Limited Duty Limits:_____ Date Began:_____

☐ Lost Time from Work Date Began:_____ Date Resumed Work:_____

CURRENT HABITS or LIFESTYLES (Please check all that apply):

☐ Tobacco ☐ Marijuana ☐ Meat Eater ☐ Nightmares

☐ Chew ☐ Cocaine ☐ Vegetarian ☐ Insomnia

☐ Alcohol ☐ MDMA/Ecstasy/Molly ☐ Vegan ☐ Apnea

☐ Soda ☐ Methamphetamine ☐ Gluten-Free ☐ Other sleep issues

☐ Caffeine ☐ Other recreational drugs ☐ Other dietary restrictions/guidelines: _____

How frequently do you indulge in any of the above? _____

PATIENT:	CHART NUMBER:	DATE:

PLEASE CHECK ANY OF THE CONDITIONS THAT APPLY TO YOU

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Anxiety
☐ Appendicitis
☐ Asthma
☐ Back Sprain
☐ Blood Clots
☐ Blood Pressure issues
☐ Breathing Difficulty
☐ Calf Pain (sudden/frequent)
☐ Cancer
☐ Carpal Tunnel
☐ Chicken Pox
☐ Degenerative Disc Disorder
☐ Diabetes
☐ Dislocation(s)
☐ Fainting/Dizzy Spells
☐ Fibromyalgia
☐ Fusions
☐ Hearing Difficulty
☐ Heartburn
☐ Heart Disease/Stroke
☐ Heart Palpitations
☐ Hepatitis
☐ Hernia
☐ HIV/AIDS
☐ Kidney disease/LNFX
☐ Liver Disease
☐ Menopause
☐ Menstrual Cramps
☐ Mental/Emotional issues
☐ Mumps
☐ Musculoskeletal DX
☐ Nausea/Vomiting
☐ Neck Sprain
☐ Osteoporosis
☐ Other Spinal Issues
☐ Painful Glands
☐ Pneumonia
☐ Polio
☐ Poor circulation
☐ Poor Eyesight
☐ Post-Concussion Syndrome
☐ PTSD
☐ Rheumatoid Arthritis
☐ Scoliosis
☐ Spinal Infection
☐ Sinusitis
☐ Small Pox
☐ Teeth Issues
☐ Thyroid Disease
☐ TMJ
☐ Tuberculosis
☐ Ulcer
☐ Vertebral Fracture
☐ Whiplash

If other please explain: _____
_____
_____

PLEASE LIST ALL CURRENT SUPPLEMENTS/MEDICATIONS/BIRTH CONTROL (Prescribed or not):

Name	Reason	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you feel you maintain a healthy lifestyle? Yes ☐ No ☐
Do you feel you have a balanced diet? Yes ☐ No ☐
Date of last menstrual cycle (if applicable): _____
Are you training for any athletic event? Yes ☐ No ☐ Type: _____
Do you exercise on a regular basis? Yes ☐ No ☐
If yes, please elaborate: _____
_____
_____

PATIENT:	CHART NUMBER:	DATE:

Lee Chiropractic
Confidential Patient Case History

Where were you born? ☐ Home ☐ Hospital ☐ Other: _____

When were you born? ☐ Premature ☐ On Time ☐ Late Length of Mother's Pregnancy:_____

Check any that apply: ☐ Natural Birth ☐ Breech ☐ C-Section ☐ Forceps ☐ Vacuum

As a child did you experience any of the following? (Check all that apply):

☐ Breastfeeding ☐ Spinal Care ☐ Serious Illness ☐ Dietary Issues ☐ Ear Infections ☐ Chair pulled out while sitting

☐ Falls out of bed/crib ☐ Shaking ☐ Head injuries ☐ Pulled by arms ☐ Fall on stairs ☐ Spanking

☐ Broken Bones ☐ Fall on Tailbone ☐ Other falls or injuries (please explain):_____

_____

Have you had to have surgery for any reason? ☐ Yes ☐ No If yes, please explain: _____

_____

Have you had any broken bones? ☐ Yes ☐ No If yes, please list: _____

_____

Do you have any metal in your body (pins, screws, etc)? ☐ Yes ☐ No If yes, where? _____

Have you had any dislocations occur before? ☐ Yes ☐ No If yes, where? _____

Have you been in an auto accident in the past ☐ 1 year ☐ 3 years ☐ 5 years ☐ 10 years ☐ Never

Date of accident(s):_____

Describe:_____

_____

_____

FAMILY HEALTH HISTORY:

Relation	Health Problems	Age
Father:		
Mother:		
Sister:		
Brother:		

Please add any other additional information you feel the doctor should be aware of regardless of how minor:

_____

_____

_____

_____

PATIENT:	CHART NUMBER:	DATE:

Lee Chiropractic Financial Policies

Payment:

Lee Chiropractic wants to help you with your health! ***Payment in full is expected at each visit*** but we pride ourselves in putting our patients first. If your economic situation changes, let our office staff know. We will do our best to work with you and make sure that everyone comes out healthy and happy.

Insurance and Medicare:

Lee Chiropractic is not a member of any insurance network and we take payment at the time of each visit. We will gladly provide you with a paper statement that you can submit to your insurance provider for partial reimbursement for the out of pocket costs.
Medicare patients will be asked to sign an ABN (Advance Beneficiary Notice of Non-Payment) at the time of treatment.

Personal Injury/Auto Accident:

We do not accept third party claims and require payment at the time of each visit, unless there is a signed Doctor's Lien from an attorney or a Medical Payment (MEDPAY) clause in the patient's automobile insurance policy. Please ask for accident specific paperwork.

Missed Appointments:

We reserve the right to charge full fees for missed appointments without prior notification. Please provide us with adequate notice (at least 24hrs) if you need to cancel or reschedule your appointment date/time.

Responsibility for Payment: We are more than happy to help you with both your care and your finances in whatever ways we can. However, all services rendered by this office are ultimately your responsibility regardless of any insurance reimbursement or settlement that you may or may not receive.

I have read the above financial policy. I clearly understand and agree that all services rendered to me by Lee Chiropractic are charged directly to me, and that I am personally responsible for payment.

_____ _____

Print Patient Name Today's Date

_____ _____

Patient Signature Parent/Guardian signature for Minor

PATIENT:	CHART NUMBER:	DATE:

Lee Chiropractic
1904 Franklin St. Ste.705
Oakland, CA 94612

Informed Patient Consent

Dear Patient,

Every type of health care is associated with some risk of potential problem(s) this includes chiropractic health care. We want you to be informed about the potential problems associated with chiropractic health care while consenting to treatment, this is called "informed consent." Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including pervious injury, medications, osteoporosis, cancer and other illness or disease or condition.

Chiropractic adjustments are the moving of bones relative to one another with either the doctor's hands or an adjusting instrument. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another doctor will treat you.

Disc Herniation and/or Bulges: Disc Herniation and/or Bulges of the neck or back may create pressure on the spinal nerve or on the spinal cord. These disc problems are frequently and successfully treated by the chiropractors and chiropractic adjustments. Occasionally chiropractic treatment may aggravate the problem, and if the disc is in a severely weakened condition, surgery may be indicated. Surgery is so rarely necessary that there are no available statistics to quantify their necessity or actual success.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones, and ligaments limit joint movement. On a rare occasion a chiropractic adjustment, traction, massage therapy, etc., may tear some muscles tissue or ligament fibers. The result is a temporary increase in pain and in treatments for resolution, but there is no long-term affect for the patient. This complication occurs so rarely that there are no available statistics to quantify their probability.

Other Problems: Occasionally there may be other problems or complications that may arise form chiropractic treatment other than those noted above. Other complications may include but not limited to burns with thermal or electrical therapy, fractures, dislocations, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and cost vertebral 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. Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have ever had. These other complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I understand that, as with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. 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 care which the doctor feels at the time, based on the facts known, are in my best interest. My signature below confirms that I have read the paragraphs above and understand the possible risks of chiropractic treatment and have the opportunity to ask questions regarding those risks. I have fully disclosed to the chiropractor any medical history regarding the specified complications and all other conditions that have caused pain in the past. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

_____ _____

Print Patient Name Today's Date

_____ _____

Patient Signature Parent/Guardian Signature for Minor

PATIENT:	CHART NUMBER:	DATE:

Lee Chiropractic
1904 Franklin St. Ste.705
Oakland, CA 94612

Acknowledgment of Receipt of Notice of Privacy Practices and Informed Patient Consent (HIPPA)

1. I have been informed a privacy notice may be provided to me prior to my signing this Consent form. The Privacy notice includes a complete description of the use and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and necessary for the Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice explained my right to obtain a copy of the Privacy Notice, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described it its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to the following communication that will be used by the Practice: a) a card, letter, or other written information mailed to me at the address provided by me; and b) telephoning and leaving a message on my answering machine or with the individual answering the phone; and c) sending an electronic mail to the address provided by me.

4. The Practice may maintain a directory of and sign-in log for individuals seeking care and treatment in the office. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

5. The Practice may use and/or disclose my PHI in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

6. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

7. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice has to right to choose to treat me. I further understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.

I acknowledge that I may receive a copy of the Practice's Notice of Privacy Practices at any time. I further acknowledge that a copy of the current notice is posted at the front desk with the Practice's Privacy Policies Manual, which outlines all of the ways in which the Practice handles my PHI.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Dr. Christine Lee, D.C., by phone at (510) 427-0189. Signature below is acknowledgement that you have received this Notice of Privacy Practice and that you have read and understand the foregoing notice, Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

Print Patient Name	Today's Date
Patient Signature	Parent/Guardian Signature for Minor

PATIENT:	CHART NUMBER:	DATE:

HIPPA HAPPENING

Lee Chiropractic
1904 Franklin St. Ste.705
Oakland, CA 94612

Patient Authorization regarding chiropractic care being provided in an "open adjusting" environment

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involve several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. Patients also use a public sign in sheet located on the front desk to record their visits.

This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters; in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjustment environment, other arrangements will be made for you. Your decisions will have no adverse effect on your care from Lee Chiropractic or on your relationships with our staff.

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Lee Chiropractic takes patient privacy very seriously. All visits are recorded with a HIPPA compliant and secure clearinghouse. Our office uses a secure calendar, separate passwords and will not share your medical records without express written permission. We do not sell or release patient information to any other facility or company.

Lee Chiropractic asks your permission for the following: (please circle and initial)

May we send you postcards from our office via the United States postal service? ☐ Yes ☐ No _____(Initials)

May we send you appointment/calendar reminders via telephone or email? ☐ Yes ☐ No _____ (Initials)

May we send you email regarding schedule changes and monthly specials? ☐ Yes ☐ No _____ (Initials)

In the event we must call/contact you, may we identify ourselves as Lee Chiropractic? ☐ Yes ☐ No _____ (Initials)

If no, how would you like for us to identify ourselves? _____

Your Signature indicates your authorization of this activity

_____ _____
Print Patient Name Today's Date

_____ _____
Patient Signature Parent/Guardian Signature for Minor