Patient Intake Form

Date_____

First Name _____

Last Name _____

Nickname _____

Address _____

City_____

State _____

Zip_____

Date of Birth ____/____/____ Age_____

SS# _____-_____-_____

Gender ☐ Male☐ Female

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Domestic Partner

Spouse/Significant Other's Name:
_____

Number of children_____

Home Phone (_____) _____-_____

Work Phone (_____) _____-_____

Fax (_____) _____-_____

Cell Phone (_____) _____-_____

Email _____

Emergency Contact _____

(_____) _____-_____

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

_____

Occupation _____

_____

Employer _____

Work Address _____
_____

Have you seen a Chiropractor before? If so, when?_____
How many adjustments have you had? ☐ 0-20 ☐ 21-50 ☐ 51-100 ☐ 101-200
Is this appointment as a result from a car accident? □ No □ Yes If Yes, please see the front desk for additional paperwork.

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

RELIEF CARE
Relief Care is the care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE
Corrective Care differs from Relief Care in that its goal is to get rid of symptoms or pain while correcting the cause of the problem. Corrective Care varies in length of time, but is more lasting. It is fixing the cause of the leak.

I authorize Jamie Stern, D.C. to render necessary services to me and I am responsible for all charges incurred.
PLEASE PRESENT YOUR INSURANCE CARD, so that we may copy card and verify benefits.

Patient/Guardian Signature _____ Date _____

All charges are due when services are rendered.

THANK YOU FOR ALLOWING US TO SERVE YOU!

Name:_____ **Date:**_____

Please check any of the symptoms that you have recently experienced.

□ Allergies/ Sinus
□ Asthma
□ Car Accident
□ Carpal Tunnel
□ Difficulty Sleeping
□ Dizziness
□ Elbow pain
□ Headaches
□ Hip pains
□ Leg pains
□ Low back pain
□ Menstrual cramps
□ Mid back pain
□ Migraine
□ Muscle tension
□ Neck pain
□ Numbness/ tingling
□ Poor posture
□ Ringing in ears
□ Shoulder/ arm pain
□ Slip or fall
□ Sports Injury
□ Stress/ irritability
□ Weight trouble
□ Other _____

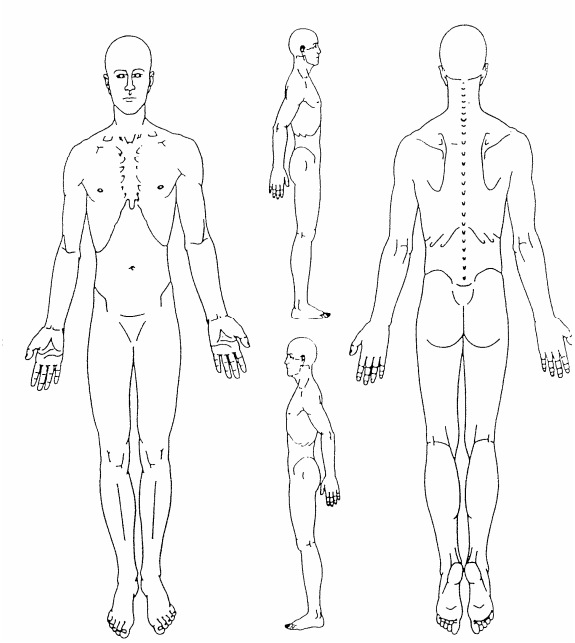
1. Which symptom would you like to get rid of the most? Why?

_____

2. If there were some things that concern you about using a Chiropractor what would they be?
_____

Use the letters below to indicate the type and location of your sensations right now:

A=Ache **B=Burning** **N=Numbness**
P=Pins & needles **S=Stabbing** **O=Other (please describe)**



Please circle one:

1. Would you like more info about how we may help you?
   Yes/ No
2. Have you tried Chiropractic care before?
   Yes/ No
3. Did Chiropractic care help you?
   Yes/ No

PATIENT QUESTIONAIRE

Is there a chance you may be pregnant? ☐ Yes ☐ No

Please list **any** accidents or injuries you've **EVER** had (head injuries, auto accidents, falls, etc.) and when:

1.) _____ Date: _____
2.) _____ Date: _____
3.) _____ Date: _____
4.) _____ Date: _____

Have you ever had any broken bones or fractures? (If so, state what & when?)

_____
_____

Please list any surgeries, hospitalizations, or medical procedures:

1.) _____ Date: _____
2.) _____ Date: _____
3.) _____ Date: _____
4.) _____ Date: _____

Please list any food allergies/sensitivities: (If so, what food & type of allergy/sensitivity?)

1.) _____
2.) _____
3.) _____
4.) _____

Please list any medications you are currently taking (over-the-counter or prescription) (also note allergies to medications):

1.) _____
2.) _____
3.) _____

Please list any supplements and vitamins you are currently taking:

1.) _____
2.) _____
3.) _____
4.) _____

Do you have a family history of the following:

☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Diabetes ☐ Stroke

Do you smoke? ☐ Yes ☐ No
Do you have a healthy diet? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No

Release of information authorized: *(for new patients)*
I authorize Jamie Stern, D.C. to release any information or office records necessary to process insurance claims. This is to serve as a long-term authorization.

Patient Signature _____ **Date**_____

Notice of Privacy Practices- H.I.P.P.A.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

State and Federal Law requires us to maintain the privacy of your health information and to inform you about our privacy practices as described below. This notice took effect on September 25, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make significant changes, this notice will be amended to reflect the changes and will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our privacy notice at any time by contacting our office. Information on contacting us can be found at the end of this notice.

Typical Uses And Disclosures of Health Information

We will keep your information confidential, using it only for the following purposes:

Treatment: We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care.

Health Care Operations: The environment in which care is provided is not completely enclosed. Thus, some incidental details about your care may be disclosed. In addition, your doctor may discuss your case and/or X-rays with another doctor in the office in order to provide the best care possible.

Disclosure: We may disclose and/or share your health with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy similar to this one. Health information may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree we may do so.

Payment: We may use your health information to seek payment for services we provide to you. This disclosure involves our business and may include other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care.

Required by Law: We may use or disclose your health information when we are required to do so by law. This includes court orders, subpoena or other lawful process.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.

Public Health Responsibilities: We will disclose your health information to report problems with products, disease/infection exposure and to prevent or control disease, injury and/or disability.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, included but not limited to, voicemail messages, postcards or letters.

Promotions and Marketing: We may use your information to send newsletters and/or notices of special promotions or events related to the office.

Your Privacy Rights as our Patient

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our office for a copy of the request form. You may also request access by sending us a letter to the address at the end of this notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $.25 for each page.

Amendment: You have the right to amend your health care information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these, but if we do, we will abide by our agreement (except in emergencies). Please contact our office if you want to further restrict access to your health care information. This request must be submitted in writing.

This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature requires that I have received a copy of this notice.

_____

Name (please print)

_____ _____

Signature Date

If you are a minor, or if another party is representing you, this notice must be acknowledged by a party authorized to act on your behalf.

_____

Name of Personal Representative (please print)

_____ _____

Signature Date

_____

Description of authority to act on behalf of the patient.

Questions and Complaints:
You have the right to file a complaint if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our office. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health care information, you can complain to us (in writing). We support your right to privacy and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

How to contact us:

Practice Name: Jamie Stern, D.C.
Telephone: (415) 308-7636
Address: 100 Bush Street, Suite 530
San Francisco, CA 94104
And
130 South Frances Street
Sunnyvale, CA 94086