California Neurohealth patient information

Patient Name_____

Address_____city_____

Zip_____ Home phone (___) ___-____ Work phone (___) ___-____

Cell phone (___) ___-____ Fax (___) ___-____

Email Address _____

Date of Birth __-__-____Age _____ social security number___-__-____

Emergency Contact _____Phone (___) ___-____

Referred by _____

Employment Status:

Full time __ Part time__ Retired__ Unemployed__ student__

Occupation_____

Employer's Name_____

Phone (___) ___-____ Employer's Address_____

Primary healthcare source:

Physician name_____Phone_____

Physician's Address_____

Date of last exam __-__-____

Chief complaint of last

exam_____

Have you ever had Acupuncture or Chiropractic Treatment? When, by Whom and for what reason?

_____

_____

Are you presently being treated for a medical Condition by a Medical Doctor? Please describe.

_____

_____

_____

Please briefly describe any chronic illness.

_____

_____

_____

What health issue(s) do you want treated? Please describe as fully as possible._____

_____

_____

_____

_____

_____

_____

What other treatments have been using for relief of this issue?

_____

_____

_____

Do you have other health concerns?

_____

_____

_____

On a scale of 0-10, 10 being someone who will do whatever it takes to get their health back and 0 being not willing to do anything , where are you on this scale?

_____

Medical Insurance Status: Self__ Private Insurance__ Medi-care__ Workmen's Comp__ Other _____

Please be respectful of our time. Your commitment begins at the moment you make an appointment. There are times when a cancellation is necessary; however please give advanced notice whenever possible. Missed or cancelled appointments with out a twenty four (24) hour notice will be charged in full. If no cancellation arrangements are made, the cost of the appointment will be charged.

Patient signature_____Date_____

"California Neurohealth informed consent"

I consent to acupuncture, Chiropractic adjustments and other procedures associated with California Neurohealth's Medical staff, (that is Licensed Acupuncturist, Chiropractic Neurologist, Guest Acupuncturist, Licensed Massage Therapist, Licensed Aesthetician, and other members of clinic's medical staff). I have discussed the nature and purpose of my treatment with the clinical staff and understand that methods of treatment may include, but not limited to acupuncture, moxibustion, cupping, electrical stimulation, massage, Chinese herbal medicine, chiropractic manipulation, therapeutic and brain based exercise, nutritional counseling and lab testing.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects. Bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur. I have been informed that chiropractic is a safe method of treatment, but that it may have side effects. Pain, bruising, increased soreness, transient tingling and numbness and fractures in patients with low bone density have all been reported and all of these risks are greatly reduced with appropriate history taking, examination and proper application of technique. Extremely rare cases of stroke temporally associated with upper neck manipulation have also been reported in medical literature but the most current and valid research shows that you are no more likely to have a stroke with chiropractic upper neck manipulation than you are with visiting your medical doctor and not receiving manipulation. Furthermore patients who receive chiropractic care have a lower risk of stroke than those who do not.

_____

Signature of patient or parent/guardian

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. **Herbal formulas and acupuncture points may have effects on pregnancy. Patients <u>Must</u> inform the practitioner of any possibility of pregnancy. I will notify my practitioner if I am or become pregnant.**

I understand that the herbs may need to be prepared and the tea consumed according to the instructions provided orally and /or in writing. The herbs may have an unpleasant smell and/or taste. I will immediately notify my practitioner of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinic medical staff to exercise judgment during the course of treatment which the clinic medical staff thinks at the time, based upon the facts then known, is in my best interests.

I understand the clinical medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntary signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

	_____
	Name of practitioner
_____	_____
Print name of patient	**Name of practitioner**
_____	_____
Signature of patient or parent/guardian	**Signature of practitioner**
_____	_____
Print name of parent/guardian of Minor	**Signature of practitioner**
_____	_____
Date of Consent Completed	**Signature of witness/ Translator**

I have read and understand HIPAA_____

California Neurohealth Patient Insurance Information

Patient Name: _____ Gender: M / F
Street Address: _____

_____

Home Phone: _____ Marital Status: M S D W
Social Security#: _____ Date of Birth: _____
Insured's Name: _____
Insured's ID/Claim#: _____ Group#: _____
Insurance Company: _____
Claims Address: _____
Insurance Company Phone Number (for Providers): _____

Type of Case (circle one): Health Insurance Workers Comp Personal Injury
Date of Injury/Accident: _____
Attorney Name (if applicable): _____
Attorney Address: _____
DIAGNOSIS: _____ _____ _____ _____ Assign Date: _____

_____

Patient Name _____ _____DOB_____
Parents or Guardian_____

_____

We ask that payment of services are made at the time of treatment. If your insurance covers acupuncture and/or chiropractic, we will bill them for you. Fees for treatment do not include the cost of herbs or supplements. Having insurance is not a substitute for payment. Many companies have fixed allowances or reimburse based on a percentage that is pre-determined on your contract with them. It is the patient's responsibility to pay the deductible, co-payment, and any other balances not paid by your insurance.
Assignment and Release:
I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Signature of patient_____Date_____

Family History and Review of Systems

Family History: please place a check in the appropriate place

	Self	Mother	Father	Sister	Brother	Child	Spouse
Allergies							
Blood Disorder							
Diabetes							
Cancer							
Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder disorder							
Stomach or intestinal disorder							
Drug abuse							
Tuberculosis							
Heart disease							
Stroke							
Depression or Mental illness							
Hormonal or Thyroid problems							
Neurological disorders							
Asthma							
Arthritis							
Chills							
fever							
Dizziness							
Fatigue							
Excess thirst							
weight loss							
weight gain							
Aversion to heat							
Aversion to cold							
Low Back Pain							
Joint disorder							
Moderate Stress level							
High Stress level							
Low Stress Level							

Please check the ones that apply:

Sleep Problems:

__Trouble falling asleep, __Trouble staying asleep,
__Trouble staying awake, __Light sleep, __wake-up tired,
__Early Morning waking , __Wake-up many times, __Lots of Dreams
How many hours do you sleep each night?

_____

Sweating:

__Rarely sweat, __Night sweats, __Excess sweating , __Spontaneous sweating

Please check the ones that apply:

Skin: __Dry, __Itchy, __Moist, __Burning, __Blood not clotting , __Hives, __Boils,
__Bruise easily , __Genital warts, __Herpes: oral/ genital, Other body Areas
__Hair loss/thinning, __Changing Mole, __Frequent Rashes, __sores
__Acne, __Puffy, __Wrinkles, __Dark Circles around eyes, Other:_____

Neurological: __Pain, __Tremors, __Seizures, __numbness, __Tingling , __Twitching
__Muscle Cramping, __Muscle Weakness, __Muscle Atrophy,
__Dizziness,
__Paralysis
Location:_____
_____
__Have you ever had a Stroke? date(s)?

_____

Post stroke problems:

_____

Head and Neck: __Concussion, __Head Aches, __Migraine Head Ache,
__Tension Head Ache, __Menstrual Migraine, __Sinus Head Ache,
__Head Ache due to Neck Injury
Location of
pain_____
__Memory Loss, __Blurred Vision, __Eye Pain, __Neck Pain ,
__Neck Stiffness.

Genito-Urinary: __Frequent Urination, __Painful or Burning upon Urination.
__Difficult Urination, __Blood in Urine,

__Frequent Infections, __stones, __unable to hold urine,
__Other_____

Ear, Nose and Throat: __Ear Aches, __Ear discharge, __Frequent Ear Infections
__Ringing in the Ear, __Poor Hearing
__Sinus problems, __Frequent Sinus Infections, __Allergies
__Frequent Colds Other_____

Chest: __Trouble Breathing , __Trouble Breathing at night,
__ Shortness of breath
__Pain/Pressure in the Chest , __Palpitations
__Mucous rattle when Breathing
__Wheezing, __Persistent Cough, __Chest Pain,
__Coughing Blood
__Coughing Phlegm, What color Phlegm?
__Have had a Heart Attack (s), Date(s):_____
__Have had Heart Surgery? _____
Date (s):_____Other:_____
_____

Emotional: __Anxiousness, __Depression, __Easily Angered, __Irritable ,
__Frequent Crying, __Moody, __Mind not Clear, __Manic,
__Obsessive __Compulsive, __Fearful, __Difficulty Expressing Emotions,
__Other: _____

Screening: Have you ever had infection screenings for:
__HIV, __TB, __Hepatitis, __Gonorrhea, __Chlamydia, __Syphilis,
__Genital warts, __Herpes: oral/ genital, Other body Areas
Which one(s) did you test positive for, if any ?

Surgeries, hospitalizations, major infections, traumas, accidents, injuries (please list-with dates):

_____
_____
_____
_____

Please check the ones that apply:

Gastro-Intestinal:

	Often	Seldom	Severe	Mild	None
Constipation					
Diarrhea					
Poor Appetite					
Excessive Appetite					
Nausea					
Vomiting					
Belching					
indigestion					
Stomach Pain					
Lower-abdominal pain					
Bloody Stool					
Black Stool					
Mucus in Stool					
Stools have Foul Odor					
Hemorrhoids					
Lower Bowel Gas					
Colon Problems					
Anal Fissures					
Intestinal Bloating					

Life Style Habits: Please indicate how much, how many, how often:

Do you drink Coffee: __Yes __No How many cups per day/week? _____

Do you use Marijuana: __Yes __No How many times per day/ week? _____

Do you smoke Cigarettes or Nicotine __Yes __No How many times per day/per week? _____

Do you drink Alcohol? __Yes __No, (type)_____amount per day/ per week _____

Recreational Drugs: __Yes __No, Which one(s) How many times per day/ week? _____

_____

Do you use Prescription pain Medications: __Yes __No
How many times per day/ week?
Please explain which kind of pain medications you are using:

_____

_____

Please take a moment and write down all the medications that you are currently taking. This page is important in prevention of herbal drug interactions.

Prescription Drugs, Please check the ones that apply:

__Blood thinning Pills, __Blood Pressure Pills, __Tranquilizers, __Antacids, __Oral Contraceptives, __Insulin, __Diabetic Pills, __Antidepressants,__Anti-Anxiety,__Steroids,__Other

Please write down Medication Names:

1._____ used for the _____ Problem
2._____ used for the _____ Problem
3._____ used for the _____ Problem
4._____ used for the _____ Problem
5._____ used for the _____ Problem
6._____ used for the _____ Problem

Over the Counter Drugs:

__Aspirin , __Antacid, __Ibuprofen, __Laxatives, __Diet Pills;__Sleeping Pills, __Acetaminophen (Tylenol), __Allergy Pills, __Cold Medicine,
Other:_____

_____

_____

Vitamins/Supplements/
Herbs:_____

_____

Do you have any drug Allergies?_____

_____

_____

Do you have any food Allergies?_____

_____

_____

Do you have a Latex, corn or wheat Allergy? __Latex__Corn__Wheat

Exercise (Type and Frequency):

_____

Briefly describe your Diet:

_____

_____

_____

_____

_____

_____

Food Cravings:

_____

_____

California Neurohealth Fertility history

__Woman Only: Age of Menarche_____ Date of last menstrual Period_____
Interval (days) between cycles____ Duration of Menses____days
Amount of bleeding __heavy __medium __light __spotting
__Bad Cramps __mild Cramps __Clots __PMS;
What PMS symptoms?_____
Contraceptive methods:_____
Number of Abortions and dates:_____
_____
Number of miscarriages and dates:_____
How far along was the pregnancy when you had the miscarriage(s)?
Reason for miscarriage if known:_____
Are you currently Pregnant? _____Due Date:_____
Date of Menopause :
Any bleeding since then?
_____
__Head Aches, __Hot Flashes, __Insomnia,
__Spontaneous Sweating, __Vaginal infections or discharge: (color of discharge)
_____
Other_____