Welcome To

TOTAL HEALTH CHIROPRACTIC CENTER

Curtis J Haake D.C.
3011 Citrus Circle, Suite 102, Walnut Creek, Ca 94598
925-930-7902

yourwalnutcreekchiropractor.com

About You:

TODAYS DATE:

NAME: SS #

ADDRESS:

CITY / STATE: ZIP CODE:

HOME PHONE: OTHER PHONE:

DATE OF BIRTH: SEX: female AGE:

E-mail: Receive our e-mail? no

OCCUPATION: How did you hear about us?

NAME OF LAST MD:

NAME OF LAST CHIROPRACTOR:

THE REASON FOR YOUR VISIT

MAJOR COMPLAINT / PAIN REGION(S)

How long in pain, distress, discomfort? Date Started:

REGION: ◯ NECK ◯ MID BACK ◯ LOW BACK ◯ ARMS ◯ LEGS ◯ HIPS ◯ SHOULDERS
◯ HANDS ◯ FEET ◯ HEADACHE ◯ JAW ◯ OTHER

Pain worst in: ◯ AM ◯ PM

Have you had this condition before? no If so, please describe:

Is the problem getting: ◯ WORSE ◯ SAME ◯ BETTER ◯ INTERMITTANT

Is the problem interfering with: ◯ WORK ◯ SLEEP ◯ DAILY ROUTINE

Please describe:

IS YOUR CURRENT CONDITION: ◯ WORK RELATED ◯ AUTO RELATED ◯ N/A

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HIPPA Protected

IN EVENT OF INJURY: Who should we contact?

Relationship:

Home # Work#

HEALTH HISTORY: **ARE YOU TAKING ANY OF THE FOLLOWING MEDI CATIONS?**

- ◯ Pain Medications (prescription or over the counter)
- ◯ Muscle Relaxants
- ◯ Stimulants
- ◯ Blood Thinners
- ◯ Tranquilizers
- ◯ Insulin
- ◯ Others:

HAVE YOU HAD ANY OF THE FOLLOWING CONDITION(S)

- ◯ Heart Attack / Stroke
- ◯ Recent Fever
- ◯ Congenital Heart Defect
- ◯ Alcohol / Drug Abuse
- ◯ HIV+ / AIDS
- ◯ Arthritis
- ◯ Frequent Neck Pain
- ◯ Fainting/Seizures/Epilepsy
- ◯ Diabetes / Tuberculosis
- ◯ Low Back Problems
- ◯ Allergies
- ◯ Heart Surgery
- ◯ Mitral Valve Prolapsed
- ◯ Venereal Disease
- ◯ Shingles
- ◯ Emphysema / Glaucoma
- ◯ Frequent Mid Back Pain
- ◯ Asthma
- ◯ Kidney Problems
- ◯ Sinus Problems
- ◯ Difficulty Breathing
- ◯ Artificial Bones / Joints
- Heart Murmur ◯
- ◯ Hepatitis
- ◯ Cancer
- ◯ Anemia
- ◯ Indigestion
- ◯ Rheumatic Fever
- ◯ Ulcers / Colitis
- ◯ Psychiatric Problems
- ◯ Chemotherapy
- ◯

OTHER SYMPTOMS YOU MAY HAVE:

- ◯ Birth Control
- ◯ Night Pain
- ◯ Abnormal weight gain / loss
- ◯ Night Sweats
- ◯ Osteoporosis
- ◯ Cigarettes'/tobacco Pks / day
- ◯ Loss of Taste
- ◯ Swollen Ankles / Feet
- ◯ Shortness of Breath
- ◯ Memory Loss

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SHOW US WHERE IT HURTS:

Please show us where you are experiencing symptoms.

Indicate your degree of pain using a scale 0 no pain to 10 extreme pain.

Numbness	pins & Needles	Burning	Aching	Stabbing
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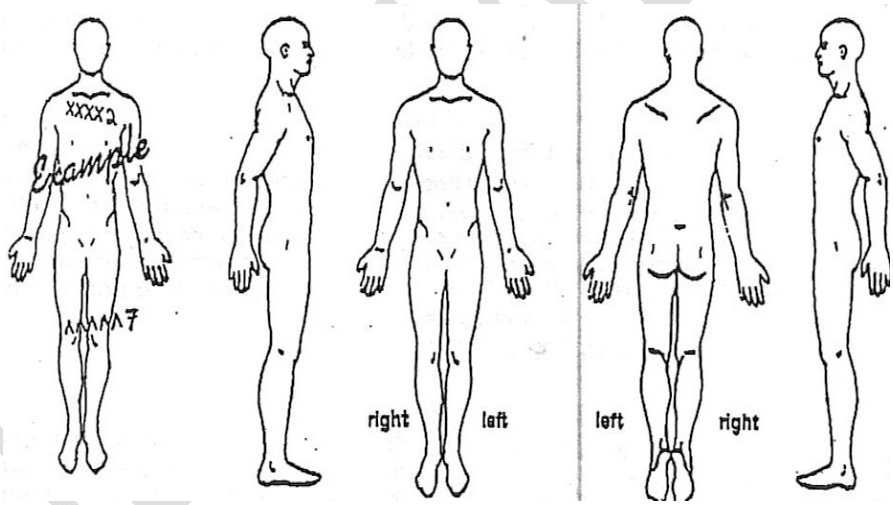

CURRENT CONDITION / COMPLAINT (HOW YOU FEEL TODAY)?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

No Pain **Unbearable Pain**

FAMILY HEALTH HISTORY: ☐ Cancer ☐ Heart Problems/Stroke ☐ Diabetes ☐ High blood Pressure ☐ Arthritis/Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition is co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

PATIENT SIGNATURE **DATE**

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

COMENTS _____

NAME: **DATE:** **SCORE:**

LOW BACK PAIN DISABILITY INDEX QUESIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild
B The pain is very mild and does not vary much
C The pain comes and goes and is moderate
D The pain is moderate and does not vary much
E The pain comes and goes and is very severe
F The pain is very severe and does not vary much

SECTION 2 -Standing

A I can stand as long as I want without pain
B I have some pain while standing but it does not increase with time
C I cannot stand for longer than 1 hour without increasing pain
D I cannot stand for longer than ½ hour without increasing pain
E I cannot stand for longer than 10 minutes without increasing pain
F I avoid standing because it increases pain immediately

SECTION 3 - Sitting

A I can sit in my chair as long as I like
B I can only sit in my favorite chair as long as I like
C The pain prevents me from sitting more than 1 hour
D The pain prevents me from sitting more than ½ hour
E The pain prevents me from sitting more than 10 minutes
F I avoid sitting because it increases pain immediately

SECTION 4 - Lifting

A I can lift heavy weights without extra pain
B I can lift heavy weights but it causes extra pain
C Pain prevents me from lifting heavy weights off the floor
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on the table)
E Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
F I can only lift very light weights

SECTION 5 - Walking

A I have no pain while walking
B I have some pain while walking but it doesn't increase with distance
C I cannot walk more than 1 mile without increasing pain
D I cannot walk more than 1/2 mile without increasing pain
E I cannot walk more than 1/4 mile without increasing pain
F I cannot walk at all without increasing pain

SECTION 6 - Sleeping

A I get no pain in bed
B I get pain in bed but it does not prevent me from sleeping well
C Because of pain my normal sleep is reduced by less than 25%
D Because of pain my normal sleep is reduced by less than 50%
E Because of pain my normal sleep is reduced by less than 75%
F Pain prevents me from sleeping at all

SECTION 7 – Social Life

A My social life is normal and gives me no extra pain
B My social life is normal but increases the degree of pain
C Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing etc).
D Pain has restricted my social life and I do not go out very often
E Pain has restricted my social life to my home
F I have hardly any social life because of the pain

SECTION 8 - Traveling

A I can travel anywhere without extra pain
B I can travel anywhere but it gives me extra pain
C Pain is bad but I manage extra journeys over 2 hours
D Pain restricts me to journeys of less than 1 hour
E Pain restricts me to short necessary journeys under 30 minutes
F Pain prevents me from traveling except to the doctor or hospital

SECTION 9 – Sex Life

A My sex life is normal and causes no extra pain
B My sex life is normal but causes some extra pain
C My sex life is nearly normal but is very painful
D My sex life is severely restricted by pain
E My sex life is nearly absent because of pain
F My pain prevents any sex life at all

SECTION 10 – Personal Care

A I do not have to change my way of washing or dressing in order to avoid pain
B I do not normally change my way of washing or dressing even though it causes some pain
C Washing and dressing increase the pain but I manage not to change my way of doing it
D Washing and dressing increase the pain and I find it necessary to change my way of doing it
4 Because of the pain I am unable to do any washing and dressing without help
F Because of the pain I am unable to do any washing and dressing without help

NAME: **DATE:** **SCORE:**

TOTAL HEALTH CHIROPRACTIC CENTER

HEALTH CARE AUTHORIZATION FORM (HIPPA)

PATIENT NAME:

THE PATIENT IDENTIFIED ABOVE AUTHORIZES TOTAL HEALTH CHIROPRACTIC CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to **Total Health Chiropractic Center** to use my address, phone number, and clerical records to contact me with birthday cards, holiday-related cards, and information about treatments or other health related information.

OPEN ROOM AUTHORIZATION

I give **Total Health Chiropractic Center** permission to treat me in an open room environment where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of my care. Should I need to speak to the doctor at any time in private; the doctor will provide a room for these conversations.

By signing this form you are giving **Total Health Chiropractic Center** permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing at any time. However, our written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reference on your authorization. New patient consent to the use and disclosure of health information for treatment, payment, or healthcare operations.

I understand that as part of my health care, **Total Health Chiropractic Center** originates and maintains paper and electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatment and any other plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to pay my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a notice of information. I understand that I have the following rights:

- The right to review the notice prior to signing consent
- The right to object to the use of my health information for directory purposes
- The right to request to restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

HEALTH CARE AUTHORIZATION FORM (continued)

I understand that **Total Health Chiropractic Center** reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 or the Code of Federal Regulations. Should **Total health Chiropractic Center** change their notice they will send a copy of any revised notice to the address I have provided; whether U.S. mail; or e-mail.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted used.

Total Health Chiropractic Center for its own uses / disclosure of permitted health information requests this authorization.

(MINIMUM NECESSARY STANDARDS APPLY)

You have the right to refuse to sign this authorization. If you refuse to sign this, **Total Health Chiropractic Center** will not refuse to provide treatment.

A copy of the signed authorization will be provided to you.

Missed Appointment Management or Re-scheduled Appointment Policy

1. After three (3) missed appointments without a phone call, patient is removed from schedule. Office staff will call you to advise you of this action.

2. If you call to re-schedule an appointment more than three (3) times, the doctor will call you directly to discuss re-scheduling policies and condition to determine whether you should continue to be scheduled.

3. If pattern continues consistently, you will be notified by phone and appropriate plans made.

4. We reserve the right to charge for cancelled or broken appointments without 24 hours notice

5. If the patient is non-compliant with in office care recommendations and home care recommendations, after three documented reminders or two weeks of care, doctor or support staff will call patient to provide instructions.

PATIENT SIGNATURE DATE