VALVERDE CHIROPRACTIC

Valverde Chiropractic Inc.

(727) 565-2562

CASE HISTORY

Name: _____ Date of Birth: _____ SSN# _____

Address: _____

Preferred contact method: Phone call, email, text Home Phone: _____ Cell: _____

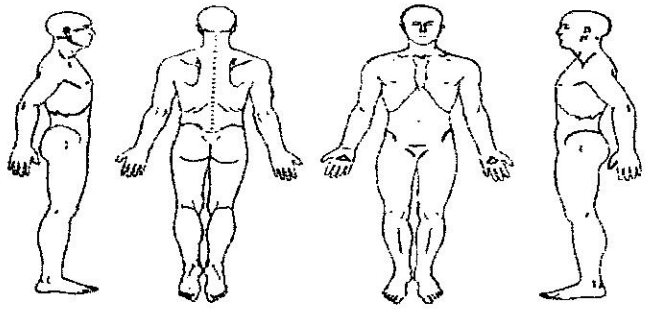
Email: _____

How were you referred to our office: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day

-afternoon -same all day

-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did, your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation

16. List any other major injuries you have had, other than those mentioned above (car accident, falls, surgery): _____

_____

17. Any other Musculoskeletal problems? ____No ____Yes Neurological problems? ____No ____ Yes

_____

18. Please list any / all Allergies: _____

19. Past Medical History: Have you ever been diagnosed as having or have suffered from one or any of the following – Please circle appropriate diagnosis: Hypertension, Rheumatoid Arthritis, Seizures/Convulsions, Congenital Disease, Exessive Bleeding, High/low Blood Pressure, Osteoarthritis, Alcoholism, Drug Addition, HIV Positive, Gall Bladder Surgery, Eating Disorder, Pace Maker, Cancer, Depression, Coughing Blood, Epilepsy, Strokes, Hernia, Ulcers, Circulatory Issues.

20. Social History:

Do you Drink Alcohol: Y N If yes, how much per week: _____

Do you smoke or use tobacco: Y N If yes, how much per day: _____

Do you take vitamin supplements: Y N If yes, please list: _____

Do you exercise: Y N If yes, what is the frequency: _____ Type of exercise:

_____

21. Family History: (Father, Mother, Brother, Sister) Family Diseases, please indicate: TB, Heart Disease, Liver Disease, Cancer, Stroke, Mental Illness, Kidney Disease, Diabetes, Lung Disease, Asthma, Arthritis, Other:

_____

22. In your visits here, we want to know what 3 activities in your life you are unable to do or are having the most difficulty with as a result of your chief compliant.

a. _____

i. Pain Level: 0 1 2 3 4 5 6 7 8 9 10

b. _____

i. Pain Level: 0 1 2 3 4 5 6 7 8 9 10

c. _____

i. Pain Level: 0 1 2 3 4 5 6 7 8 9 10

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

VALVERDE
CHIROPRACTIC

CHIROPRACTIC INFORMED CONSENT

PATIENT NAME:

Informed Consent

Informed consent for your Chiropractic care is a process and dialogue with your Chiropractic physician about the goals, risks, and alternative treatment options to allow you to participate in and make knowledgeable decisions about your Chiropractic care. It is very important that you, the patient, read this document in its entirety. As a patient, it is essential that you knowledgeably participate in decisions concerning the nature and course of your Chiropractic training - it is essential that you ask questions and receive sufficient information from your Chiropractic physician about the potential risks, proposed benefits, and alternatives to your proposed Chiropractic treatment plan. Please DO NOT SIGN this document until you have read this document in its entirety, and have had the opportunity to ask questions about your care and fully understand the care to be rendered.

Chiropractic Treatment

The practice of Chiropractic medicine includes many standard examination and testing procedures. These may include a physical examination, orthopedic and neurological testing, palpation, specialized instruments, laboratory tests, radiology examinations, physical therapy modalities, and rehabilitative procedures, among others.

The primary therapy utilized in your Chiropractic treatment will be spinal manipulative therapy or adjustments. There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand, but may be performed by hand guided instruments. A Chiropractic adjustment is by application of a quick precise movement to a specified contact point of a vertebra or other joint to improve a Chiropractic manipulation or adjustment may cause an audible “pop" or “click” similar to what you have experienced when you "crack your knuckles”. You may also feel a sense of movement at the area adjusted.

Probability and nature of risks inherent in chiropractic adjustment or treatment.

As with any health care procedure, there are, certain complications that may arise during Chiropractic manipulation and therapy. The relationship of complications from manipulation has been the subject of tremendous disagreement. Some literature has suggested that you may rarely incur fractures, disc injuries, dislocations. Occasionally after manipulation and therapy you may experience muscle strain, increased or radicular tingling, numbness, or pain. Some patients will feel stiffness and soreness after the first few days of treatment.

Some manipulations of the neck have been associated with exceedingly rare injuries to arteries in the neck or stroke, paralysis, or neurologic dysfunctions. The incidence of stoke is exceedingly rare and is estimated to occur in between one in one million and one in five million cervical adjustments.

Availability and nature of other treatment options.

Other treatment options for your conditions may include;

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, pain killers, and others
- Hospitalization
- Surgery

If you choose to use any other above noted other treatment options you should be aware that there are risks and benefits of such options, you may wish to discuss these with your primary medical physician.

Risks and Dangers of Remaining Untreated

Remaining untreated may result in persistent or increasing pain or other symptomatology, increased loss of function, formation of adhesions contributing to a pain reaction further reducing mobility, or worsening of your condition. Over time, if you choose to remain untreated, this may complicate future treatments and make future treatment difficult and less effective the longer treatment is postponed

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK SIGN BELOW.

I have read I or have had read to me the above explanation of the Chiropractic manipulation and related treatment. I have discussed the goals, risks, and alternative treatment options with Dr. Valverde and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment, and hereby agree to any or all of the aforementioned Chiropractic treatments referred to in this consent.

Patient Name: _____ Date: _____

Patient Signature: _____

Doctor Name: Manuel A. Valverde Date: _____

Doctor Signature: _____

VALVERDE
CHIROPRACTIC

Chiropractic Office HIPAA Form

THIS NOTICE PERTAINS TO PRIVACY MEASURES TO ALL DOCTORS AND MASSAGE THERAPISTS PRACTICING WITH VALVERDE CHIROPRACTIC, INC.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent to the Doctor (the Practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) this is protected under federal privacy law for the sole purpose of treatment, payment and healthcare operations.

I have reviewed the privacy policy of the Practice prior to signing this consent. The privacy policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment or healthcare operations. While the practice is not required to agree to restrictions, the practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following address / phone number / fax number / e-mail address:

_____

The practice may communicate confidential information about me to the following individual(s):

_____

_____ _____

Signature of Patient/patient representative Date