

Whom may we thank for referring you to this office → _____?

APPLICATION FOR CARE AT MOUNTAIN VALLEY FAMILY CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: Single Married Do you have Insurance: Yes No

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

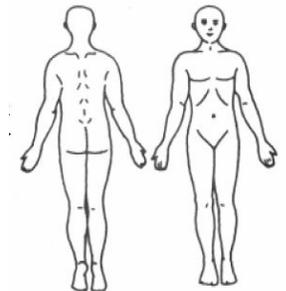
Name of Previous Chiropractor: _____ N/A

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____



LIST RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

_____ :	_____	_____
_____ :	_____	_____
_____ :	_____	_____
_____ :	_____	_____

Is your problem the result of ANY type of accident? Yes, No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes** how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: No Yes **If yes**, please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____ What were the results. Favorable Unfavorable → please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never have had**:

- ___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
- ___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

SOCIAL HISTORY

- 1. **Smoking:** cigars pipe cigarettes → How often? Daily Weekends Occasionally Never
- 2. **Alcoholic Beverage:** consumption occurs → Daily Weekends Occasionally Never
- 3. **Recreational Drug use:** Daily Weekends Occasionally Never
- 4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following, See pg 2- Activities of Life

FAMILY HISTORY:

- 1. Does anyone in your family suffer with the same condition(s)? No Yes
If yes whom: grandmother grandfather mother father sister's brother's son(s) daughter(s)
Have they ever been treated for their condition? No Yes I don't know
- 2. **Any other hereditary conditions the doctor should be aware of.** No Yes: _____

I hereby authorize payment to be made directly to Mountain Valley Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Mountain Valley Family Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

Activities of Daily Living/Symptoms/Medications

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

Please mark P for in the Past, C for Currently have and N for Never

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) |

List Prescription & Non-Prescription drugs you take: _____

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures? _____

(i.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field _____

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) Values? _____

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly:

Doctor Signature: _____

Date: _____

OUR OFFICE POLICIES

Welcome to Mountain Valley Family Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read “Our Office Policies”, if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your *Application for Care*, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone’s best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY** - Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

□ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Mountain Valley Family Chiropractic** is rendered primarily to minimize and reduce subluxations (misalignments in the spine), which are a major interference to the expression of the body’s innate wisdom. The doctors use a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

□ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

□ **PATIENT’S REPORT OF FINDINGS** - To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a ‘Doctors Report of Findings’. The information you receive at this appointment will be both informative and clinically relevant to your case; therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors’ recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient’s family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Mountain Valley Family Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Pala at (650) 787-1844. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

JDD,DC 5/2011