Registration and History

South OC Chiropractic

Patient's Name: _____ Today's Date: _____

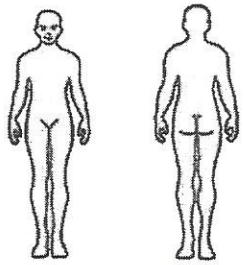
1 Patient Condition

Chief complaint _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ NA

Activities or movements that are painful: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ NA

2 Medical History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition:

_____

Date of Last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____ Chest X-ray _____
MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

AIDS/HIV	☐ Yes ☐ No	Chemical Depend./ Alchohalism	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Clotting Disorder	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Anxiety/Depression	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	STD	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Epilepsy/Seizure Dis.	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Autoimmune Dis.	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	MS	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Cancer	☐ Yes ☐ No			Parkinson's	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
						☐ Other _____	

3 Family History

Autoimmune Dis.	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	☐ Other _____
Bleeding Disorder	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	
Clotting Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No	

Are you pregnant? ☐ Yes ☐ No

Please list all injuries/surgeries you have had:	Description	Date
Falls:		
Head Injuries:		
Broken Bones/Fractures:		
Dislocations:		
Surgeries:		

South OC Chiropractic
Phone (949) 470-4757
Email: drmhamilton@gmail.com
southocchiropractic.com

4 Lifestyle

South OC Chiropractic

Exercise	Work Activity	Habits	Values
☐ None	☐ Sitting	☐ Smoking	Please list your interests in order of importance from 1 to 7 (1= most important)
☐ Light	☐ Standing	☐ Alcohol	_____Family _____Financial _____Social _____Physical
☐ Moderate	☐ Light Labor	☐ Coffee/Caffeine Drinks	_____Mental _____Spiritual _____Work
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	

5 Medications | Vitamins/Supplements | Allergies

1) _____
2) _____
3) _____

Pharmacy Name: _____

Pharmacy Phone: (____) _____

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

☐ Daily ☐ Weekly ☐ Occasionally

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

How often do they occur? _____

6 Patient Information

Patient Name (Last Name) _____ (First Name) _____ (Middle Initial) _____

Email: _____ Primary Phone: _____ ☐ Home ☐ Cell ☐ Work

Address: _____ City: _____

State: _____ Zip: _____ Sex ☐ M ☐ F Age: _____ Birth Date: _____

Social Security/DL # _____ ☐ Married ☐ Single ☐ Partnered

Occupation: _____ Patient Employer/School: _____

Address: _____ Phone: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you? Event you attended? _____

7 Payment/Insurance Information

Who is responsible for this account? _____

☐ Self-Pay Name(s) of responsible parties: _____

Relationship to patient: _____

☐ Government Program Name: _____ ID # _____

☐ Health Insurer Name: _____ ID # _____ Group # _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

Is this policy associated with an ☐ HSA ☐ FSA ☐ HRA? ☐ Yes ☐ No

Is patient covered by additional/ secondary insurance? ☐ Yes ☐ No

Insurance Co. Name: _____ ID # _____ Group # _____

Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

8 Family Information

Children's Name(s)	Sex	Date(s) of Birth	Children's Name(s)	Sex	Date(s) of Birth
_____	M F	_____	_____	M F	_____
_____	M F	_____	_____	M F	_____
_____	M F	_____	_____	M F	_____

South OC Chiropractic

Phone (949) 470-4757
Email: drmhamilton@gmail.com
southocchiropractic.com

Now comes a man. Any one man is a SMALL thing. This man gives an adjustment. The adjustment is a SMALL thing. The adjustment replaces the subluxation. That is a SMALL thing. The adjusted subluxation releases pressure upon nerves. That is a SMALL thing. The released pressure restores health to a man. That is a BIG thing to that man.

– Dr. D.D. Palmer

South OC Chiropractic

Dr. Micah Hamilton, D.C.
South OC Chiropractic
23792 Rockfield Blvd. Suite 210
Lake Forest, CA 92630

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____**Gender (Circle one):** Male / Female **Preferred Language:**_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Height: _____ Weight:_____ Blood Pressure:_____/_____

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

South OC
Chiropractic

CONSENT TO CHIROPRACTIC CARE

Congratulations for choosing the safest and most natural health care program ever conceived: Chiropractic.
This painless, logical, and effective approach to health has been serving everyday people for over 100 years. It is licensed in every state, and in many countries as well. Chiropractic has the least chance of side effects of any other type of health care. Mild headaches and muscles soreness may sometimes occur.

Let's look at a few statistics about possible serious side effects:

The #1 cause of death in the US is from correctly and incorrectly prescribed pharmaceutical drugs. (CDC, FDA, NIH sites, also Gary Null: Death By Medicine)
Stroke is one of the most common causes of death in the US. With people going to doctors all the time it is probable that many will have had a recent doctor visit. But causation is another matter entirely.
There is no absolutely known material risk of chiropractic care being greater than risks from medical treatment. In fact, when all the factors are taken together, deaths and injuries from a combination of medical mistakes and intentional drugs dwarf any injuries from chiropractic.

Risk of stroke from chiropractic? Virtually zero chance of stroke from chiropractic. The largest study ever done – the 2008 study in Canada – www.belleviewchiro.com/index.php?p=213660 – looking at 12 million people over 9 years, showed that 53% of strokes had visited their MD within 30 days prior, while only 4% had visited their DC. No evidence of excess risk of stroke associated with chiropractic care.
In 2001 the Canadian Medical Association Journal found there is only a one-in-5.85-million risk that a cervical manipulation from an MD, PT, or DC would be followed by a stroke. Author David Cassidy, a professor of epidemiology at the University of Toronto said patients had already damaged the artery before seeking help from either a medical doctor or a chiropractor, and then the stroke occurred after the visit.
Speaking of risks associated with chiropractic, we should look also at the risk associated with NOT GETTING adjusted. This risk was one of the 4 components of risk in the Association of Chiropractic Colleges guidelines on informed consent in 2008.

Disc degeneration, loss of mobility, loss of overall tone, decreased quality of life – these are real risks of the untreated spine as time goes by.
Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:
a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:
b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibly of such injuries resulting from upper cervical spinal adjustment is extremely remote;
c) There is rare reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.
Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spam, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment os substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same treatments.
I acknowledge the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Sign	Print	Date

South OC Chiropractic

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have received a copy of South OC Chiropractic's Notice of Privacy Practices.

_____
Print Patient's Name

_____ _____
Signature of Patient or Legal Guardian Date

****For Office Use Only****

If patient wishes not to sign this notice, please indicate time and date notice was given, also state reason and provide documentation that the patient refused to sign waiver.

(Employee signature is sufficient)

information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding:

Disclosures and Changes to Your Medical Information

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or heath care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request you must tell us what information you want to limit.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Your Access to Medical Information

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about your, you must submit your request in writing to the privacy officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed heath care professional chosen by this practice will review your request and the denial. The person conducting the review will not be that person who denied your request. We will comply with the outcome of the review.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Office at this practice.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communication sent. To request confidential communication, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complains must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

South OC Chiropractic Notice of Privacy Practices

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who will follow this notice?

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and location of this practice may share medical information with each other for treatment, payment purposes or heath car operation as stated in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies or prior injuries or surgeries that could influence our treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

- <u>Other Uses or Disclosures That Can be Made Without Your Consent or Authorization</u>
  - As required during an investigation by law enforcement agencies
  - To avert a serious threat to public health or safety
  - As required by military command authorities for their medical records
  - To worker's compensation or similar programs for processing of claims
  - In response to a legal proceeding
  - To a coroner or medical examiner for identification of a body
  - If an inmate, to the correctional institution or law enforcement official
  - As required by the US Food and Drug Administration (FDA)
  - Other healthcare providers treatment activities
  - Other covered entities' and providers' payment activities
  - Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
  - Uses and disclosures required by law
  - Uses and disclosures in domestic violence or neglect situations
  - Health oversight activities
  - Other public health activities

We may contact you to provide appointment reminders or information about treatment and other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medial information about your, you may revoke that authorization, in writing, at any time. IF you revoke your authorization, we will thereafter no longer use or disclose medical