Confidential Patient Information

DATE

HOW DID YOU COME TO THIS CLINIC? WHO REFERRED YOU? _____

IS YOUR VISIT DUE TO AN ACCIDENT? ☐YES ☐NO (IF YES, PLEASE COMPLETE THIS AND THE ACCIDENTAL INJURY REPORT)

PATIENT INFORMATION

NAME_____ HOME PHONE _____ WORK PHONE_____

CELL PHONE _____ EMAIL ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTHDATE _____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

OCCUPATION _____ DRIVER'S LIC. # _____ SS# _____

EMPLOYER _____ EMPLOYER ADDRESS _____

SPOUSE _____ OCCUPATION _____ WORK PHONE _____

EMPLOYER _____ EMPLOYER ADDRESS _____

NAME OF EMERGENCY CONTACT _____ PHONE _____

PRESENT COMPLAINT

BRIEFLY DESCRIBE YOUR SYMPTOMS _____

LIST OTHER DOCTORS SEEN FOR THIS CONDITION _____

MEDICAL HISTORY **(If any of the following are relevant to your medical history, please check the accompanying box.)**

☐CANCER	☐MUSCULAR DYSTROPHY	☐RHEUMATIC FEVER
☐POLIO	☐MULTIPLE SCLEROSIS	☐SCARLET FEVER
☐TUBERCULOSIS	☐CONVULSIONS	☐NERVOUSNESS
☐HIGH BLOOD PRESSURE	☐EPILEPSY	☐ASTHMA
☐HEART TROUBLE	☐CONCUSSION	☐DIGESTIVE DISORDERS
☐DIABETES	☐DIZZINESS	☐SINUS TROUBLE
☐HEPATITIS	☐ARTHRITIS	☐BACKACHES
☐GERMAN MEASLES	☐NEURITIS	☐NUMBNESS
☐VENEREAL DISEASE	☐RHEUMATISM	☐ANEMIA

DESCRIBE ANY OPERATIONS YOU HAVE HAD _____ WHEN? _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐YES ☐NO

DESCRIBE CONDITION _____ DATE OF LAST PHYSICAL EXAM _____

ARE YOU ALLERGIC TO ANY MEDICATION? ☐YES ☐NO WHAT KIND? _____

ARE YOU TAKING ANY MEDICATION? ☐YES ☐NO WHAT KIND? _____

IF FEMALE, ARE YOU PREGNANT? ☐YES ☐NO DATE OF LAST MENSTRUAL PERIOD? _____

INSURANCE DATA **(Clinic policy requires payment arrangements be made on the first visit)**

NAME OF PARTY RESPONSIBLE FOR PAYMENT _____ PHONE (_____) _____

DO YOU HAVE INSURANCE? ☐YES ☐NO COMPANY _____

PLEASE LIST ALL SOURCES OF INSURANCE

PATIENT'S INSURANCE _____ SPOUSE'S INSURANCE _____

WORKER'S COMPENSATION _____ CLAIM NUMBER, IF OPEN _____

OTHERS _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE OR GUARDIAN'S SIGNATURE _____ DATE _____

If yours is an accident/injury, please complete the Accidental Injury Report as well

Gilroy Health & Wellness Center
Robert W. Kovacs, D.C.
7888 Wren Ave Ste. B-123
Gilroy, CA 95020

Informed Consent Document

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Chiropractor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Chiropractor's attention, it is your responsibility to inform the Chiropractor.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Robert Kovacs, DC, to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other chiropractors and/or office staff members and is intended to include radiographic examination at the chiropractor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to that treatment.

Dated: _____

_____ _____

Patient's Name **Patient's Signature**

_____ _____

Parent or Guardian's Name (if a minor) **Signature of Parent or Guardian (if a minor)**

Gilroy Chiropractic Center
7888 Wren Ave, Ste B-123
Gilroy, CA 95020
(408)848-3666

HIPAA Privacy Practices Consent

Name of Patient: _____

Date of Birth: _____

I acknowledge that I have read and understand the Gilroy Chiropractic Center HIPAA Notice of Privacy Practices and have received a written copy if requested. If I am not the patient, I represent that I am authorized by law to act on the patient's behalf.

_____ _____
Signature **Date**

If not signed by patient, indicate authority to act for patient: _____

FOR OFFICE USE ONLY

COMPLETE IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient or patient's authorized representative because:

_____ Individual refused to sign
_____ Other (please describe) _____

_____ _____
Signature Date

WELLNESS HISTORY

Patient's Name: _____ Date _____

1) Please check any of the following symptoms you have experienced in the last 6 months:

❑ Headaches/Migraines	❑ Elbow/Wrist/Hand pain	❑ Herniated/Degenerated Disc
❑ Neck pain	❑ Carpal Tunnel Syndrome	❑ Stenosis (nerve canal narrowing)
❑ Mid back pain	❑ Tingling / Numbness	❑ Dizziness / Vertigo
❑ Arm/ Shoulder pain	❑ Lower back pain	❑ Balance Problems
❑ Whiplash	❑ Sciatica (pain in leg)	❑ Restless Leg Syndrome
❑ Scoliosis (curved spine)	❑ Hip / Leg pain	❑ Tremor disorder
❑ Fibromyalgia	❑ Knee/Ankle/Foot pain	❑ Peripheral Neuropathy
❑ Arthritis/Osteoarthritis	❑ Insomnia	❑ High Cholesterol
❑ Ringing in ear	❑ Thyroid problem	❑ Diabetes (high blood sugar)
❑ Sinus/Allergies	❑ Digestive problems	❑ High Blood Pressure
❑ Other_____	❑ Chronic Fatigue / Tiredness	

Which of the above is the worst? _____

When did you first have this condition? _____

How often do you get it? _____

How long does it last when you have it? _____

Where is it located exactly? _____

What type of pain is it? ❑ Sharp ❑ Dull ❑ Burning ❑ Aching ❑ Other _____

Does it radiate or travel anywhere?_____

Is this problem: ❑ Getting worse ❑ Staying the same ❑ Getting better-please explain

_____

Describe how this condition feels at its worst _____

What kinds of activity make this problem worse? (sitting, standing, sports, hobbies)

_____

Is there anything that temporarily helps this condition? _____

Do you feel this condition will go away on its own and not return? ❑ Yes ❑ No

Which of the above conditions is the *second* worst? _____

When did you first have this condition? _____

How often do you get it? _____

How long does it last when you have it? _____

Where is it located exactly? _____

What type of pain is it? ❑ Sharp ❑ Dull ❑ Burning ❑ Aching ❑ Other _____

Regarding this *second* problem: Does it radiate or travel anywhere?_____

Gilroy Health and Wellness Center 7888 Wren Ave Ste B-123 Gilroy, CA, 95020

WELLNESS HISTORY

Is this problem: ❑ Getting worse ❑ Staying the same ❑ Getting better-please explain

_____

Describe how this condition feels at its worst _____

What kinds of activity make this problem worse? (sitting, standing, sports, hobbies)

_____

Is there anything that temporarily helps this condition? _____

Do you feel this condition will go away on its own and not return? ❑ Yes ❑ No

2) Describe how the above condition(s) affect you when they are at their worst:

❑ Moody ❑ Irritable ❑ Lose patience with others ❑ Less fun to be with
❑ Help less around the house ❑ Feel Nauseous ❑ Restricted in motion
❑ Have to lie down ❑ Don't want to do anything ❑ Other _____
❑ Interrupts sleep - Explain_____
❑ Restricts daily activities- Explain_____
❑ Hinders recreational activities-Explain _____
❑ They have no effect on me

3) Since the time you began suffering from these problems, what have you tried to do to get rid of them that has not worked permanently?

❑ Prescription Medications: Results_____
❑ Injections: Results _____
❑ Over-the-counter Medications: Results_____
❑ Surgery: Results _____
❑ Massage: Results _____
❑ Exercise: Results_____
❑ Physical Therapy: Results _____
❑ Chiropractic: Results _____
❑ Acupuncture: Results _____
❑ Home remedies: Please explain _____
❑ Other: Please explain _____

4) Are you <u>currently</u> seeing:

a) Any other <u>Specialists</u> or <u>Health Care Providers</u>?

Who:_____ For: _____
Who:_____ For: _____

b) Chiropractor? ❑ Yes ❑ No For?:_____

If No: ❑ Have you ever? When: _____ Did it help? _____

Have you ever received spinal decompression treatments? ❑ Yes ❑ No

c) Physical Therapist? ❑ Yes ❑ No For:_____

❑ Have you ever? When: _____ Did it help? _____

WELLNESS HISTORY

5) Is there anything else that these problems are preventing you from doing, either totally or partially, that you would really like to be doing again? ❑ Yes ❑ No

Please explain: _____

_____

6) What is your current occupation or past occupation (if retired)? _____

What type of work is involved mostly? (lifting, sitting, standing, etc) _____

_____

7) <u>If working</u>, are you less productive on your job because of these health problems? ❑ Yes ❑ No

Do you enjoy your work less because of these problems? ❑ Yes ❑ No

Do you have to take more breaks? ❑ Yes ❑ No

8) Healing occurs when you are asleep and sleep is essential to a proper immune system. Having problems with sleep is a complicating factor, which makes healing more difficult.

Do you have: 1) Trouble falling asleep due to being uncomfortable? ❑ Yes ❑ No

2) Not enough restful sleep? ❑ Yes ❑ No

3) Awaken in the middle of the night? ❑ Yes ❑ No

4) Waking earlier than you normally would? ❑ Yes ❑ No

9) When was the last time you woke up feeling good? _____

10) Is this problem negatively impacting your relationships with your loved ones, friends, colleagues, or others? ❑ Yes ❑ No

11) Have you had to just learn to live with these problems? ❑ Yes ❑ No

12) Do you feel the quality of your life has decreased as a result of these problems? ❑ Yes ❑ No

13) If these problems are left untreated, do you feel they will get worse? ❑ Yes ❑ No

How do you feel that would affect you? _____

_____

(develop arthritis? become bedridden? or become unable to function normally?, etc.)

WELLNESS HISTORY

14) Comparing your health now to 5-10 years ago, do you feel your overall health is:

❑ Improving ❑ Getting Worse ❑ Staying the Same

15) What would life be like if you got these problems corrected and they didn't return?

_____

_____

16) Would you feel younger if you didn't have these problems? ❑ Yes ❑ No

How many years younger would you feel? _____

17) We believe that a person's health is more important than anything else.
Without your health, you can't enjoy life. No matter how much money or material possessions a person has, they would always want their health first.

Do you agree that your health should be your top priority? ❑ Yes ❑ No

18) Do you feel it's time to do something about this problem?

❑ Yes ❑ No

19) On a scale of 1 to 10, 10 being the most committed and 1 being the least committed, please rate your commitment to getting your health problems handled:

Please circle one: (low priority) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (top priority)

If not 10, please explain: _____

_____

20) Please check off which tests you have had in the past:

❑ MRI – area: ❑ Neck – when _____ ❑ Low Back – when _____

❑ Knees – when _____ ❑ Left ❑ Right ❑ Both

❑ Other area: _____ when _____

❑ CT SCAN – area: ❑ Neck – when _____ ❑ Low Back – when _____

❑ Other area: _____ when _____

❑ X-RAYS – area: ❑ Neck – when _____ ❑ Low Back – when _____

(If Spine X-rays): Were they taken: ❑ Standing? ❑ Seated? or ❑ Lying down?

❑ Knees – when _____ ❑ Left ❑ Right ❑ Both

❑ Other area: _____ when _____

❑ Other area: _____ when _____

WELLNESS HISTORY

Check off below any other conditions or symptoms you currently have or recently

CONDITION	Frequency	CONDITION	Frequency
❑ ADD/ADHD - learning problems		❑ Heart Murmur	
❑ Allergies - Food		❑ High Cholesterol	
❑ Anemia		❑ Hypersomnia (sleeping too much)	
❑ **Aneurysm**		❑ Hypoglycemia (low blood sugar)	
❑ Arteriosclerosis – Hardening of the Arteries		❑ Hemorrhoids	
❑ DJD		❑ Insomnia	
❑ Asthma / Emphysema		❑ Irregular Heart Rate	
❑ Auto-Immune Disease		❑ Joint Cramps / Joint Pain	
❑ Bed wetting		❑ Kidney Problems	
❑ Bladder / Urination Problems		❑ Libido Decreased	
❑ Bloating		❑ Liver Problems	
❑ Blood Pressure-low/high		❑ Low Resistance to Infections	
❑ Bronchitis / cough / Breathing problems		❑ Male = Prostate problem / Impotence	
❑ Candida Albicans / Yeast Infections		❑ Female = Menopause / Hot Flashes	
❑ Chest Pain / Pneumonia		❑ Memory Loss (loss of concentration	
❑ Colds (chronic) / sore throat / Tonsillitis		❑ **Osteoporosis / Osteopenia**	
❑ Constipation		❑ Over / Under Weight	
❑ Depression		❑ PMS / Menstrual problems / cramps	
❑ Stomach Problems / Nausea / ❑ Ulcer		❑ Poor Circulation / Cold Hands or Feet	
❑ Diarrhea / Colitis / Gas		❑ Psoriasis	
❑ Ear Infections / Earaches		❑ Seizures	
❑ Eye Trouble / Vision difficulty		❑ Shingles	
❑ Edema / water retention (swelling feet)		❑ Shortness of Breath	
❑ Epilepsy		❑ **Pacemaker? ❑Yes ❑No When: _____**	
❑ Failed Surgery - Back / Neck / Wrist		❑ Skin Disorders / Eczema / Hives / Acne	
❑ Fainting Spells		❑ Stiffness	
❑ Gall bladder problems		❑ TMJ	
❑ Hearing problems		❑ Varicose veins	
❑ Rapid Heart Rate /Arrythmia		❑ Weakness or Cramps in Legs	
❑ Heart Disease – Cardiovascular Disease		❑ Weight Gain / Weight Loss	

Please list any other complaints or concerns that you wish you could get rid of, even if you wouldn't necessarily think that it's something we could help you with: _____

Do You Smoke? ❑ No ❑ Yes-How Much? _____ **Do You Drink? ❑ No ❑ Yes-How Much?_____**

What Prescribed Medications are you currently taking?_____
_____
_____
_____

What Over-The-Counter Medications are you taking?_____
_____
_____

What Vitamins or Supplements are you taking?
_____
_____

Do you have a history of:

- ❑ Cancer? Date_____
- ❑ Gall Stones? Date_____
- ❑ Heart Attack? Date_____
- ❑ Stroke? Date_____
- ❑ Surgery?
  - *For_____ Date_____
  - *For _____Date_____

PLEASE FILL OUT NEXT PAGE

WELLNESS HISTORY

1) Do you take various vitamins, minerals, herbs or homeopathic remedies without being absolutely sure what you really need? ❒ Yes ❒ No

2) Have you ever been tested to find out what vitamins or minerals you *really* need? ❒ Yes ❒ No

3) Did you know that taking vitamins, minerals or herbs ***randomly*** can cause Nutritional Deficiencies? ❒ Yes ❒ No

4) Do you have trouble losing weight or keeping it off? ❒ Yes ❒ No

5) Do you eat less than you used to but still can't lose weight? ❒ Yes ❒ No

6) Would you like to know if your metabolism has slowed down, causing lack of energy, weight gain or trouble losing weight? ❒ Yes ❒ No

7) Would you like to find out how to slow down your aging process *naturally* from the inside out? ❒ Yes ❒ No

8) Would you like to find out if underlying Nutritional Deficiencies or Imbalances are causing ***<u>any</u>*** health problems? ❒ Yes ❒ No

9) Would you like to find out what are the best foods for <u>YOU</u> based on testing? ❒ Yes ❒ No

10) Would you like to find out how to reduce your risks of Cancer, Heart Attack, Stroke and other serious health conditions? ❒ Yes ❒ No

11) Would you like to watch a short video that explains the program to find the answers to these questions? ❒ Yes ❒ No