PATIENT CONFIDENTIAL INFORMATION

First Name _____ M.I. _____ Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone (Area Code/No.) _____ Work Phone (Area Code/No.) _____ Cell Phone (Area Code/No.) _____

Social Security No. ___-___-___ Birthdate ___/___/___ Single _____ Married _____ Sex _____ Age _____ Height _____ Weight _____

Your Employer _____ Your Job Title _____

Employer's Street Address _____ City _____ State _____ Zip Code _____ Spouse's Name _____

Spouse's Employer _____ Spouse's Employer's Street Address _____ City _____ State _____ Zip Code _____

E-mail address _____ Emergency Contact: _____ Phone _____

Do you have insurance? ☐ Yes ☐ No If yes, Company:

Automobile Accident Patients: Automobile Insurance Carrier: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that: 1.) This office will prepare any necessary reports and forms to assist me in making collection from the insurance company. 2.) There may be a fee and I will be informed of the amount prior to completion of the forms or reports. 3.) Any amount authorized to be paid directly to this office will be credited to my account upon receipt.

I authorize 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. It is my understanding that my credit may be checked if Capital Valley Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made.

I understand that if it is necessary to refer my account(s) to an outside collection agency, I will be responsible for any additional court costs, attorney fees, and any other collection charges.

In compliance with HIPPA regulations, I have received a copy of Capital Valley Chiropractic's Privacy Policy. _____ (Initial Here)

I hereby authorize the Doctors of Capital Valley Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Signature _____ Date _____ / _____ / _____

CONSENT FOR TREATMENT OF A MINOR CHILD

I hereby authorize Dr. _____ and/or whomever he may designate to administer Chiropractic care as deemed necessary to _____ (Name of Minor), my _____ (Relationship to Minor).

Patient Signature _____ Date _____ / _____ / _____

Revised: 1/28/17

HISTORY OF COMPLAINT

Please list below each symptom that you are concerned about and would like to discuss with your doctor. Please take your time and list each symptom separately. For example, if you have; neck pain, pain between the shoulders, headaches, and pain radiating down your right arm, - each of these symptoms should be listed and described in detail separately. This will give your doctor a detailed understanding of your concerns and a better opportunity to help you.

It's been our Doctor's experience that patients may begin to notice additional symptoms for the first time, weeks or even months after their injury occurred. There are a variety of reasons this may occur such as; the intensity of the most severe symptoms lessens the degree that other symptoms are noticed initially, or resuming previously normal activities that your injuries had precluded you from – now brings out a symptoms that previously had not existed. If this happens to you please tell your Doctor as soon as possible.

What bothers you the most? _____

How often is this symptom present? ☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Intermittently (26-50%) ☐ Occasionally (0-25%)

How intense is this symptom? ☐ Severe (Unable to do anything) ☐ Moderate (Able to perform with altered movements) ☐ Slight (Bothersome, no alter) ☐ Minimal (An annoyance)

Does this symptom radiate anywhere? ☐ No ☐ Yes: If yes, where? ☐ Left Arm ☐ Right Arm ☐ Left Leg ☐ Right Leg ☐ Other _____

Describe what your symptom feels like: ☐ Sharp/Stabbing ☐ Burning ☐ Shooting ☐ Knotting/Tight/Tense ☐ Dull ☐ Throbbing ☐ Tingling ☐ Weakness ☐ Numbness ☐ Soreness ☐ Achey ☐ Other: _____

When did this symptom begin? ☐ Date ____/____/____ ☐__ days ago ☐ __ weeks ago ☐ __ Months ago ☐ __ Years ago

Is this symptom: ☐ Better when you first wake up ☐ Better in the middle of the day ☐ Worse by the end of the day ☐ Worse when you first wake up, better in the middle of the day, the worse again by the end of the day

Since this symptom began, is it: ☐ Improving ☐ Getting Worse ☐ Improves, then gets worse again ☐ No change

What gives this symptom relief? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐ Exercise ☐ Inactivity/rest ☐ Other: _____

What else bothers you? _____

How often is this symptom present? ☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Intermittently (26-50%) ☐ Occasionally (0-25%)

How intense is this symptom? ☐ Severe (Unable to do anything) ☐ Moderate (Able to perform with altered movements) ☐ Slight (Bothersome, no alter) ☐ Minimal (An annoyance)

Does this symptom radiate anywhere? ☐ No ☐ Yes: If yes, where? ☐ Left Arm ☐ Right Arm ☐ Left Leg ☐ Right Leg ☐ Other _____

Describe what your symptom feels like: ☐ Sharp/Stabbing ☐ Burning ☐ Shooting ☐ Knotting/Tight/Tense ☐ Dull ☐ Throbbing ☐ Tingling ☐ Weakness ☐ Numbness ☐ Soreness ☐ Achey ☐ Other: _____

When did this symptom begin? ☐ Date ____/____/____ ☐__ days ago ☐ __ weeks ago ☐ __ Months ago ☐ __ Years ago

Is this symptom: ☐ Better when you first wake up ☐ Better in the middle of the day ☐ Worse by the end of the day ☐ Worse when you first wake up, better in the middle of the day, the worse again by the end of the day

Since this symptom began, is it: ☐ Improving ☐ Getting Worse ☐ Improves, then gets worse again ☐ No change

What gives this symptom relief? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐ Exercise ☐ Inactivity/rest ☐ Other: _____

Patient Signature _____ Date _____ / _____ / _____

(Complete on an additional sheet if you have more concerns)

Revised: 1/28/17

ADDITIONAL COMPLAINTS (If Needed)

Is there anything else that bothers you? _____

How often is this symptom present? ☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Intermittently (26-50%) ☐ Occasionally (0-25%)

How intense is this symptom? ☐ Severe (Unable to do anything) ☐ Moderate (Able to perform with altered movements)
☐ Slight (Bothersome, no alter) ☐ Minimal (An annoyance)

Does this symptom radiate anywhere? ☐ No ☐ Yes: If yes, where? ☐ Left Arm ☐ Right Arm ☐ Left Leg ☐ Right Leg
☐ Other _____

Describe what your symptom feels like: ☐ Sharp/Stabbing ☐ Burning ☐ Shooting ☐ Knotting/Tight/Tense
☐ Dull ☐ Throbbing ☐ Tingling ☐ Weakness
☐ Numbness ☐ Soreness ☐ Achey ☐ Other: _____

When did this symptom begin? ☐ Date ____/____/____ ☐__ days ago ☐ __ weeks ago ☐ __ Months ago ☐ __ Years ago

Is this symptom: ☐ Better when you first wake up ☐ Better in the middle of the day ☐ Worse by the end of the day
☐ Worse when you first wake up, better in the middle of the day, the worse again by the end of the day

Since this symptom began, is it: ☐ Improving ☐ Getting Worse ☐ Improves, then gets worse again ☐ No change

What gives this symptom relief? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting
☐ Movement ☐ Exercise ☐ Inactivity/rest ☐ Other: _____

Is there anything else that bothers you? _____

How often is this symptom present? ☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Intermittently (26-50%) ☐ Occasionally (0-25%)

How intense is this symptom? ☐ Severe (Unable to do anything) ☐ Moderate (Able to perform with altered movements)
☐ Slight (Bothersome, no alter) ☐ Minimal (An annoyance)

Does this symptom radiate anywhere? ☐ No ☐ Yes: If yes, where? ☐ Left Arm ☐ Right Arm ☐ Left Leg ☐ Right Leg
☐ Other _____

Describe what your symptom feels like: ☐ Sharp/Stabbing ☐ Burning ☐ Shooting ☐ Knotting/Tight/Tense
☐ Dull ☐ Throbbing ☐ Tingling ☐ Weakness
☐ Numbness ☐ Soreness ☐ Achey ☐ Other: _____

When did this symptom begin? ☐ Date ____/____/____ ☐__ days ago ☐ __ weeks ago ☐ __ Months ago ☐ __ Years ago

Is this symptom: ☐ Better when you first wake up ☐ Better in the middle of the day ☐ Worse by the end of the day
☐ Worse when you first wake up, better in the middle of the day, the worse again by the end of the day

Since this symptom began, is it: ☐ Improving ☐ Getting Worse ☐ Improves, then gets worse again ☐ No change

What gives this symptom relief? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting
☐ Movement ☐ Exercise ☐ Inactivity/rest ☐ Other: _____

Is there anything else that bothers you? _____

How often is this symptom present? ☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Intermittently (26-50%) ☐ Occasionally (0-25%)

How intense is this symptom? ☐ Severe (Unable to do anything) ☐ Moderate (Able to perform with altered movements)
☐ Slight (Bothersome, no alter) ☐ Minimal (An annoyance)

Does this symptom radiate anywhere? ☐ No ☐ Yes: If yes, where? ☐ Left Arm ☐ Right Arm ☐ Left Leg ☐ Right Leg
☐ Other _____

Describe what your symptom feels like: ☐ Sharp/Stabbing ☐ Burning ☐ Shooting ☐ Knotting/Tight/Tense
☐ Dull ☐ Throbbing ☐ Tingling ☐ Weakness
☐ Numbness ☐ Soreness ☐ Achey ☐ Other: _____

When did this symptom begin? ☐ Date ____/____/____ ☐__ days ago ☐ __ weeks ago ☐ __ Months ago ☐ __ Years ago **Is this symptom:** ☐ Better when you first wake up ☐ Better in the middle of the day ☐ Worse by the end of the day
☐ Worse when you first wake up, better in the middle of the day, the worse again by the end of the day

Since this symptom began, is it: ☐ Improving ☐ Getting Worse ☐ Improves, then gets worse again ☐ No change

What gives this symptom relief? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting
☐ Movement ☐ Exercise ☐ Inactivity/rest ☐ Other: _____

Patient Signature _____ Date _____ / _____ / _____

Revised: 01/28/17

GENERAL HEALTH HISTORY

Is your visit due to an accident or a work-related injury? ☐ Yes ☐ No (If yes, please see receptionist for an injury report.)
List other doctor(s) seen for this condition _____
Have you ever seen a Chiropractor before? ☐ Yes ☐ No If yes, when was the last time? _____

General Medical History (if any of the following are relevant to your medical history, please check accompanying box:)

Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	Cancer	☐	☐	Diabetes	☐	☐	Heart Condition	☐	☐	Arthritis
☐	☐	Polio	☐	☐	Epilepsy	☐	☐	High Blood Pressure	☐	☐	Depression
☐	☐	Tuberculosis	☐	☐	Hepatitis	☐	☐	Asthma	☐	☐	Blood Disorder
☐	☐	Muscular Dystrophy	☐	☐	Scarlet Fever	☐	☐	Venereal Disease	☐	☐	Fainting

Describe any other conditions the Doctor should be aware of: _____

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No If yes, describe condition _____

Are you now taking any medication? ☐ Yes ☐ No If yes, what kind? _____
Are you allergic to any medication? ☐ Yes ☐ No If yes, what kind? _____
Are you pregnant? ☐ Yes ☐ No If no, date of last menstrual period: _____.

PAST HEALTH HISTORY

1.) HOSPITALIZED / SURGERY ☐ Yes ☐ No If yes, describe: _____

Did you fully recover? ☐ Yes ☐ No Do you have any limitations as a result ☐ Yes ☐ No Any restrictions as a result ☐ Yes ☐ No

2.) ACCIDENTS (AUTO/FALLS) ☐ Yes ☐ No If yes, describe: _____

Did you fully recover? ☐ Yes ☐ No Do you have any limitations as a result ☐ Yes ☐ No Any restrictions as a result ☐ Yes ☐ No

3.) ACCIDENTS OF THE JOB ☐ Yes ☐ No If yes, describe: _____

Did you fully recover? ☐ Yes ☐ No Do you have any limitations as a result ☐ Yes ☐ No Any restrictions as a result ☐ Yes ☐ No

4.) IMPORTANT FAMILY HEALTH HISTORY: _____

_____ Date _____ / _____ / _____
Signature

Revised: 01/28/17

CHIRORACTIC INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

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 I use as a Doctor 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 Material 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. I 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 my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

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

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

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. James Nolen, D.C., and have had any questions answered to my satisfaction. 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 hereby give my consent to that treatment.

Date _____ / _____ / _____

_____
Patient Signature

Date _____ / _____ / _____

James R. Nolen, D.C.
Doctor's Name

_____
Signature of Parent or Guardian (if a minor)

_____
Doctor's Signature

HEALTH CARE OPERATIONS: We have an open filing system but it is off limits to the public and only authorized personnel is allowed access.

You may receive therapy in a public area where you may be seen by others.

WORKERS COMPENSATION: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

EMERGENCIES: We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH: As required by law, we may disclose your health information to public health authorities for purposes related to; preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS: We may disclose your health information to coroners or medical examiners.

ORGAN DONATION: We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

SPECIALIZED GOVERNMENT AGENCIES: We may disclose your health information for military, national security, prisoners and government benefits purposes.

MARKETING: We may contact you for marketing purposes as described below:

- We may put patient's names or photos in public view in our waiting room or treatment rooms as a way of acknowledging them.
- We may call our patient to remind them of appointments, or reschedule missed appointments.
- We may leave a reminder regarding your appointment on an answering machine, or with the person that answers the phone. No personal health information will be disclosed.

CHANGE OF OWNERSHIP: In the event that Capital Valley Chiropractic is sold or merged with another organization, your health information/records will become property of the new owner.

I have read this Privacy Notice and understand the policies contained this notice.

Patient's Printed Name	Patient's Signature	Date
_____	_____	_____ / _____ / _____

Revised: 08/09/17

YOUR HEALTH INFORMATION RIGHTS

You have the right to request restrictions on certain uses and disclosures of you health information. Please be advised, however, Capital Valley Chiropractic is not required to agree to the restrictions you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have the right to request that Capital Valley Chiropractic amend your protected health information. Please be advised, however that Capital Valley Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
You have the right to receive an accounting of disclosures of your protected health information made by Capital Valley Chiropractic.

You have a right to a paper copy of the Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES:

Capital Valley Chiropractic reserves the right to amend the Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Capital Valley Chiropractic is required by law to comply with this notice.

Capital Valley Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Privacy Officer, Kanani Nolen by calling this office at (916) 786-0111. If Kanani Nolen is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of April 14, 2003.

I have read this Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Capital Valley Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____	_____	_____ / _____ / _____
Patient's Printed Name	Patient's Signature	Date
_____	_____	_____ / _____ / _____
Authorized Facility Printed Name	Authorized Facility Signature	Date

Revised: 08/09/17