Confidential Patient Record

Name _____ Sex _____ Age _____ DOB _____ Date _____

Address _____ City _____ State _____ Zip _____

Home _____ Business _____ Mobile _____ Email _____

Occupation _____ Employer _____

Names/Ages of Children _____ Marital Status (circle one) MARRIED SINGLE WIDOWED DIVORCED

Name of Spouse _____ Spouse's Employer _____

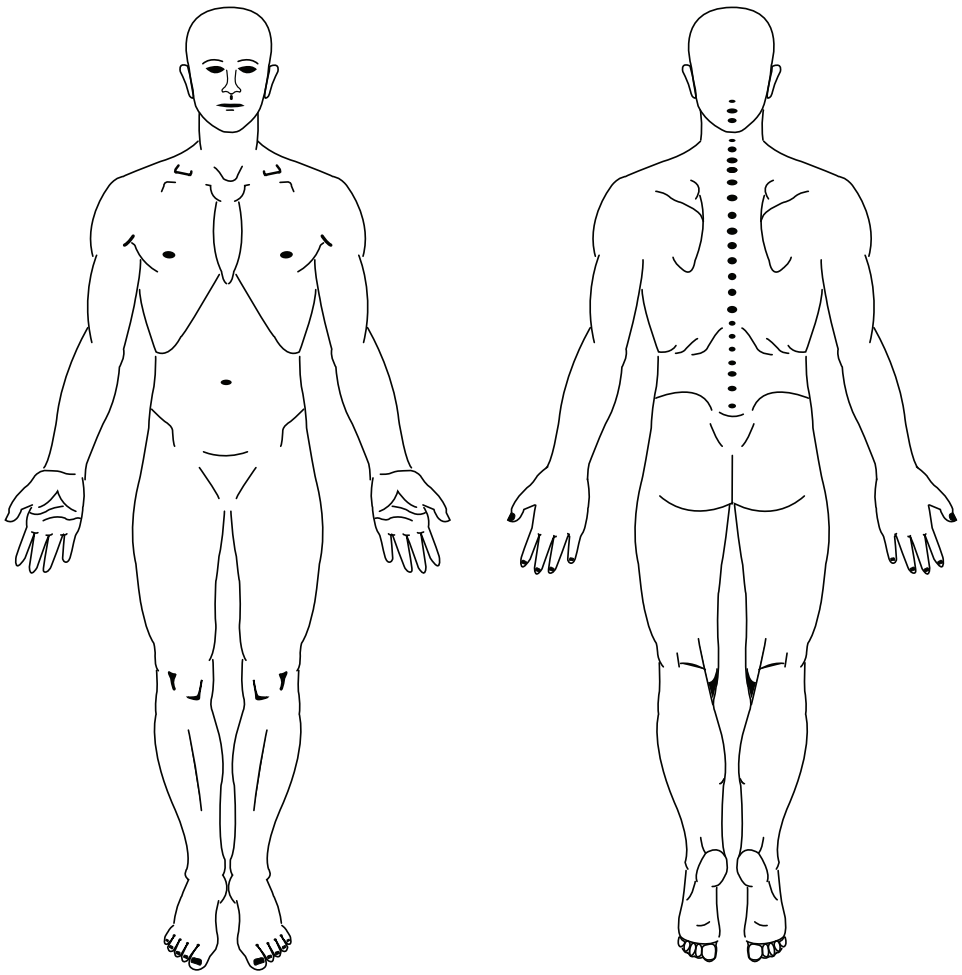
Name and Phone of Emergency Contact _____ Relationship _____

Have you ever been to a chiropractor before? Y N If yes, which doctor? _____

Chose clinic because/Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other
Email address:	Are you interested in receiving clinic newsletters?		

HEALTH EVALUATION

Using the diagram below, mark the areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). You can also write notes next to your markings if a description would be helpful. Then, please answer the questions to the right by circling the number that best represents your pain, where 1 is no pain and 10 is pain as bad as you can imagine.



Scars: Use the diagrams to the left to draw any scars (major or minor) that you have.

Rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain on AVERAGE for the past WEEK.

1 2 3 4 5 6 7 8 9 10

PERSONAL HABITS & LIFESTYLE

Please check all that apply

How many cups, bottles, or glasses do you drink on the average per day?

- ☐ Beer _____
- ☐ Coffee _____
- ☐ Fruit juice _____
- ☐ Herbal tea _____
- ☐ Alcohol _____
- ☐ Milk _____
- ☐ Soft drinks (diet) _____
- ☐ Soft drinks (regular) _____
- ☐ Tea (Black/Green) _____
- ☐ Vegetable juice _____

What is your source of your drinking water? What temp. do you drink it?

- ☐ Bottled (spring)
- ☐ Distilled
- ☐ Filtered
- ☐ Tap
- ☐ Well
- ☐ Hot
- ☐ Cold
- ☐ Room temp.

What is your current weight information?

Present weight: _____
Normal Weight: _____
Weight 1 year ago: _____
Minimum weight: _____ When? _____
Maximum weight: _____ When? _____

What is your energy level?

- ☐ I feel worn out
- ☐ I feel drowsy
- ☐ I have low output
- ☐ I feel slowed down in my thinking
- ☐ I feel energetic
- ☐ I can do lots in a day
- ☐ I feel in good shape
- ☐ I feel rested upon waking
- ☐ I can concentrate well.

Are you on a specific diet? For how long?

- ☐ Non vegetarian _____
- ☐ Vegetarian _____
- ☐ Vegan _____
- ☐ Low carb _____
- ☐ Low fat _____
- ☐ Other: _____

How many times do you eat at restaurants per week?

Do you watch television? ☐ Yes ☐ No
Do you take vacations? ☐ Yes ☐ No
Do you spend time outside? ☐ Yes ☐ No
How many hours of sleep do you get on the average? _____
Do you feel refreshed in the morning? ☐ Yes ☐ No
Do you often feel overworked? ☐ Yes ☐ No

What do you do for exercise? Indicate frequency, intensity and duration.

- ☐ Aerobics _____
- ☐ Bicycling _____
- ☐ Breathing exercises _____
- ☐ Gardening _____
- ☐ Jogging _____
- ☐ Swimming _____
- ☐ Walking _____
- ☐ Weightlifting _____
- ☐ Yoga _____
- ☐ Other: _____

How would you describe your present level of personal stress?

- ☐ Minimal
- ☐ Average
- ☐ Considerable
- ☐ Unbearable

What do you do to relieve stress?

What is the main stressor?

- ☐ Expectations
- ☐ Family Members
- ☐ Financial
- ☐ Health
- ☐ Other: _____
- ☐ Interpersonal
- ☐ Job related
- ☐ Marriage
- ☐ Spiritual

Have you ever used recreational drugs? ☐ Yes ☐ No

If so, how much and how often? _____
Years since quitting: _____

Have you ever used tobacco? In what form? ☐ Yes ☐ No
If so, how much and how often?
Years since quitting: _____

MUSCULOSKELETAL

PAST	CURRENT		PAST	CURRENT	
❑	❑	Arthritis	❑	❑	Joint swelling
❑	❑	Backaches	❑	❑	Muscle spasms or cramps
❑	❑	Broken bones	❑	❑	One arm or leg shorter
❑	❑	Burning on soles of feet	❑	❑	Unusual redness of palms
❑	❑	Joint pain	❑	❑	Weakness
❑	❑	Joint stiffness			

MEDICATIONS

Please list any medications you are taking, or have taken in the past, and for how long. State the reason for taking it.

- ❑ Antacids
- ❑ Antibiotics
- ❑ Antidepressants
- ❑ Antihistamines
- ❑ Anti-inflammatories
- ❑ Birth Control Pills
- ❑ Blood Pressure Medication
- ❑ Cardiac/Heart Medication
- ❑ Diuretics
- ❑ Hormones (estrogen, progesterone, DHEA, testosterone, thyroid)
- ❑ Muscle Relaxors
- ❑ Pain Killers
- ❑ Parasite Medication
- ❑ Steroids (prednisone, anabolics, cortisone)
- ❑ Yeast/Fungal Medications

_____

_____

SURGERIES / HOSPITALIZATIONS | Please indicate any surgeries, traumas, fractures, car accidents, etc. that you have had.

❑ Appendectomy ❑ Implants/Prostheses ❑ C-Sections ❑ Eye Surgery ❑ Laparoscopy
❑ Arthroscopy ❑ Biopsies ❑ D&Cs ❑ Implants/Prostheses ❑ Tonsils/Adenoids

Other (please list all with brief details such as date, outcome, etc.) _____

FAMILY HISTORY | Check those that apply and indicate the outcome and age of onset.

	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Mother	Father	Brother	Sister	Onset	Outcome	
Allergies	❑	❑	❑	❑	❑	❑	❑	❑			
Arthritis (type)	❑	❑	❑	❑	❑	❑	❑	❑			
Asthma	❑	❑	❑	❑	❑	❑	❑	❑			
Cancer (type)	❑	❑	❑	❑	❑	❑	❑	❑			
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑			
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑			
Mental Disease	❑	❑	❑	❑	❑	❑	❑	❑			
Thyroid Imbalance	❑	❑	❑	❑	❑	❑	❑	❑			

Other _____

REVIEW OF SYSTEMS | Please check the "NOW" box for all conditions that you are now experiencing and mark the "PAST" box for any condition or symptoms experienced at any time in your life.

	◀ PAST	◀ CURRENT
General		
Weight loss	❑	❑
Weight gain	❑	❑
Head		
Headache	❑	❑
Dizziness	❑	❑
Head trauma	❑	❑
Fainting	❑	❑
Blacking out	❑	❑
Eyes		
Change in vision	❑	❑
Cataracts	❑	❑
Light sensitivity	❑	❑
Flashes in vision	❑	❑
Spots in vision	❑	❑
Mouth		
Bleeding gums	❑	❑
Cold sores	❑	❑
Dentures	❑	❑
Sore throat	❑	❑
Jaw pain	❑	❑
Changes in taste	❑	❑
Hoarseness	❑	❑

	◀ PAST	◀ CURRENT
Nose		
Nosebleeds	❑	❑
Sinus problems	❑	❑
Lungs		
Difficulty breathing	❑	❑
Asthma	❑	❑
Pneumonia	❑	❑
Wheezing	❑	❑
Persistent cough	❑	❑
Coughing phlegm	❑	❑
Coughing blood	❑	❑
Tuberculosis	❑	❑
Vascular		
Chest pain	❑	❑
Palpitations	❑	❑
Ankle swelling	❑	❑
Cold feet/hands	❑	❑
Leg cramps	❑	❑
Calf pain	❑	❑
Varicose veins	❑	❑
Low blood pressure	❑	❑
High blood pressure	❑	❑

	◀ PAST	◀ CURRENT
G-I System		
Gas	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Ulcers	❑	❑
Vomiting/Nausea	❑	❑
Abdominal Pain	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Blood in stool	❑	❑
Hemorrhoids	❑	❑
Gall bladder disease	❑	❑
Liver disease	❑	❑
G-U System		
Difficulty urinating	❑	❑
Pain urinating	❑	❑
Blood in urine	❑	❑
Incontinence	❑	❑
Foul odor of urine	❑	❑
Increased urination	❑	❑
Decreased urination	❑	❑
Urinary infection	❑	❑
Genital infection	❑	❑

	◀ PAST	◀ CURRENT
Neurologic		
Seizures/Epilepsy	❑	❑
Strokes	❑	❑
Tingling sensation	❑	❑
Numbness	❑	❑
Weakness	❑	❑
Difficulty walking	❑	❑
Poor coordination	❑	❑
Muscle/Bone		
Joint pain	❑	❑
Stiffness	❑	❑
Muscle ache	❑	❑
Arthritis	❑	❑
Bone pain	❑	❑
Fractures	❑	❑
Dislocations	❑	❑
Skin		
Rash	❑	❑
Bruising	❑	❑
Brittle nails	❑	❑
Changes in moles	❑	❑
Itching	❑	❑
Peeling	❑	❑

	◀ PAST	◀ CURRENT
Conditions		
Hypertension	❑	❑
Diabetes	❑	❑
Thyroid condition	❑	❑
Heart condition	❑	❑
Rheumatic arthritis	❑	❑
Rheumatic fever	❑	❑
Glaucoma	❑	❑
Alcoholism	❑	❑
Cancer/Tumor	❑	❑
Polio	❑	❑
Parkinson's	❑	❑
Multiple Sclerosis	❑	❑
Gout	❑	❑
Anemia	❑	❑
Osteoporosis	❑	❑
Osteoarthritis	❑	❑
High cholesterol	❑	❑
Migraines	❑	❑
TIAs	❑	❑
Headache unlike any previously experienced	❑	❑

FEMALE REPRODUCTIVE

PAST	CURRENT		PAST	CURRENT	
❑	❑	Infertility	❑	❑	Menses scanty flow
❑	❑	Difficulty feeling sexual arousal	❑	❑	Menses excessive flow
❑	❑	Painful sex	❑	❑	Menses regular
❑	❑	Vaginal itching/burning	❑	❑	Cycle greater than 32 days
❑	❑	Discharge from vagina	❑	❑	Cycle less than 24 days
❑	❑	Herpes	❑	❑	Alternating menses cycle length
❑	❑	Genital eruptions	❑	❑	Bleed/spotting between periods
❑	❑	Venereal disease	❑	❑	Pain and cramping during menses
❑	❑	Nipple discharge	❑	❑	Breast pain and swelling during menses
❑	❑	Lumps in breast	❑	❑	Water retention during menses
❑	❑	Menses absent	❑	❑	Mental fogginess
❑	❑	Have you had uterine bleeding since menopause?	❑	❑	Disinterest in sex
❑	❑	Hot flashes	❑	❑	Mood swings
❑	❑	Painful intercourse	❑	❑	Depression
❑	❑	Increased vaginal pain, dryness or itching	❑	❑	Facial hair growth
❑	❑	Decreasing breast size	❑	❑	Acne

_____ Date of last mammogram

Have you ever used birth control pills? ☐ Yes ☐ No If so, for how long? _____

Side effect? _____

Have you ever used an IUD? ☐ Yes ☐ No If so, for how long? _____

Side effect? _____ What kind of IUD ? _____

Are you currently sexually active ☐ Yes ☐ No Current form of contraception _____

Did you have a normal puberty? ☐ Yes ☐ No Age of first menstruation _____

Are your periods regulars ☐ Yes ☐ No Periods occur every _____ Days

Date of last period: _____ Do you do breast self exams? ☐ Yes ☐ No

Date of last PAP smear: _____ Was it normal? ☐ Yes ☐ No

Have you had in the past or currently have problems with infertility? ☐ Yes ☐ No _____

# of pregnancies _____ # of births _____ # of miscarriages _____ # of abortions _____

Any complications of pregnancy? ☐ Yes ☐ No If yes, please explain: _____

Sexual preference ☐ Heterosexual ☐ Bisexual ☐ Homosexual

Informed Consent

I, the undersigned, have voluntarily requested that In Health Clinic, Ly Ho Chiropractic Corporation (IHC) and Light & Joy Acupuncture Inc. (LJA) assist me in the management of my health concerns. I have understood and agree to all policies and terms provided in the Office Policies and Procedures. I understand that IHC and LJA are chiropractic, Chinese Medicine and massage services that are not to be construed or serve as a substitute for standard medical care. IHC and LJA recommend that I undergo regular routine medical check-up by my medical doctor. Medical doctors, doctors of chiropractic, osteopaths, acupuncturist and physical therapists who perform examination are required by law to obtain your informed consent before starting treatment.
I, the undersigned do hereby give my consent to the performance of chiropractic and acupuncture treatment. I understand that methods of treatment may include but are not limited to: acupuncture, acupressure, therapeutic massage, bioelectrical stimulation, moxibustion, cupping therapy, medical qi gong, and manipulations/adjustment involving the movement of the joints and soft tissues. Physical therapy, home exercises, and nutritional supplements/dietary recommendations may also be used.

Routine examination and treatment involve some of the following methods:
Observation: General assessment/appraisal in all postures.
Inspection: Viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, back, and side. All symptomatic (painful) body parts may be viewed. Women may continue wearing their bra in the course of examination unless it obscures visualization/viewing of injured/abnormal body parts. Women may request a female observer be present at any time during examination and/or treatment.
Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.
Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
Percussion: Using a rubber hammer and tapping on bones or tendons.
Orthopedic/neurological testing: These are standard tests to assess your neuromusculoskeletal systems.

Although spinal manipulation/adjustment and Chinese Medicine are considered to be the safest, most effective methods of treatment for health problems, I am aware that there are possible risks and complications associated with these procedures as follows:
Risks from Treatment
Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform IHC and LJA if you experience these symptoms.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor immediately.
A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.
Herbs/Nutraceutical: Possible side effects from taking herbs are nausea, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. Some herbs may be inappropriate during pregnancy.
Acupuncture: unusual risks of acupuncture may include infections, spontaneous miscarriage, minor nerve damage, and organ punctures. We comply with strict protocols for clean needle technique and associated healing modalities. I understand while this document describes the possible risks of treatments, other side effects may occur.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available
Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.
Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic and Chinese Medicine treatments. The practitioner has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Signature of patient/legal guardian: _____ Date: _____

I discussed the procedures, alternatives, and risks in conference with the patient.

Practitioner signature: _____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In Health Clinic, Ly Ho Chiropractic Corporation (IHC) and Light & Joy Acupuncture Inc. (LJA) are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

"It is our policy to provide a substitute healthcare provider, authorized by IHC and LJA to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situation."

Every effort will be made to protect your privacy. If you are at all uncomfortable, please inform any of our staff. Our answering machine is not a closed system. When messages are retrieved, there is a chance your message could be overheard. Again every effort is made to take messages off the machine with your privacy considered. Staff monitors our filing area at all times, as it is separate from the treatment rooms.

Worker's Compensation: We may disclose health information as necessary to comply with State Workers' Compensation Laws.

Emergencies: We may disclose 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 emergency or of your death.

Public Health: As required by law, we may disclose 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 law enforcement officials 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.

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 to the general public.

Specialized Government Agencies: We may disclosure health information for military, national security, prisoner and government benefit purposes.

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

As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this reporting or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

As a service to our patients, it is our policy to occasionally send a health newsletter or a flyer regarding upcoming health classes offered on our premises. It is not our policy to disclose any personal health information about your condition for the purposes of these marketing mailings.

It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the date and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purposes of IHC and LJA fund-raising events.

Occasionally we will send birthday or holiday greetings or health reminders to our patients. It is not our policy to disclose any personal health information about your condition in these mailings.

Change of Ownership: In the event that IHC or LJA is sold or merged with another organization, your health information/record will become the property of the new owner.

Changes to this Notice of Privacy Practices

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

IHC and LJA are 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 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: IHC and LJA by calling this office at 408-358-0270. If IHC and LJA are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy Rights, or how IHC and LJA has handled your health information should be directed to IHC and LJA by calling this office at 408-356-0270. If IHC and LJA are 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

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

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

_____
Patient's Name (print)

_____ _____
Patient's Signature Date