Sonoran Wellness & Rehab
4140 E Baseline Rd, Suite 103, Mesa, Az, 85206
(480) 233-9505

Patient History

Name:_____ Age:_____ DOB:_____

Gender: (circle one) Male Female Height:_____ Weight: _____

Occupation: _____

Home Phone:_____ Cell Phone:_____

Email:_____ Preferred Language:_____

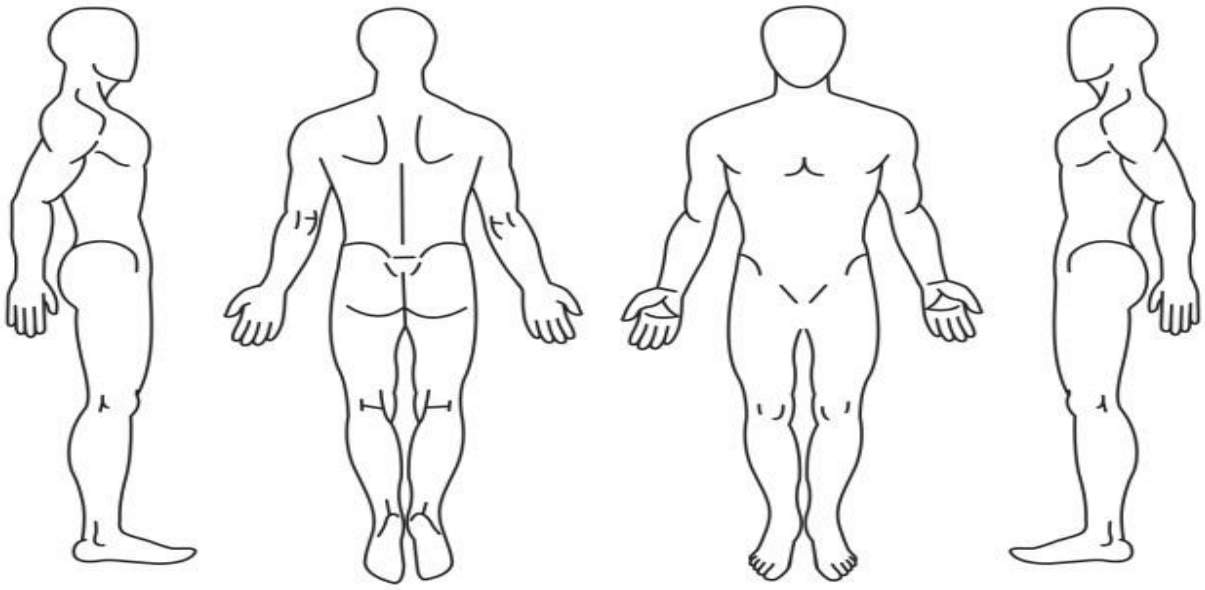
Do you have any allergies?_____

1) Have you had Chiropractic care before?_____ if Yes when? _____

2) Reason for today's visit? (circle one) Pain Stiffness Maintenance Care Other

If other explain: _____

3) Place an X below on any area that is abnormal



4) Where is your Primary complaint today?_____

How did this pain occur? Or is it insidious?_____

Rate this pain between 1-10 with 1 being minimal and 10 being severe (circle one)

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: (circle) Sharp Dull Achy Tingling Numbness Burning

Inflamed Throbbing Radiating

Frequency of Pain: (circle one) Constant Frequent Occasional

When did your complaint(s) first begin? _____

As of today is the condition: (circle one) Worse Same Better

What helps and/or worsens this condition? _____

When is pain worse? Morning Midday Evenings All Day

Does the pain travel?_____

5) Where is your Secondary complaint today?_____

How did this pain occur? Or is it insidious?_____

Rate this pain between 1-10 with 1 being minimal and 10 being severe (circle one)

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: (circle) Sharp Dull Achy Tingling Numbness Burning

Inflamed Throbbing Radiating

Frequency of Pain: (circle one) Constant Frequent Occasional

When did your complaint(s) first begin? _____

As of today is the condition: (circle one) Worse Same Better

What helps and/or worsens this condition? _____

When is the condition worse? Morning Midday Evenings All Day

Does the pain travel?_____

6) Where is your Tertiary complaint today?_____

How did this pain occur? Or is it insidious?_____

Rate this pain between 1-10 with 1 being minimal and 10 being severe (circle one)

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: (circle) Sharp Dull Achy Tingling Numbness Burning Inflamed

Throbbing Radiating

Frequency of Pain: (circle one) Constant Frequent Occasional

When did your complaint(s) first begin? _____

As of today, is the condition: (circle one) Worse Same Better

What helps and/or worsens this condition? _____

When is the condition worse? Morning Midday Evenings All Day

Does the pain travel?_____

7) Have you experienced these complaints previous? (circle) Yes No

If so when?_____

8) If currently experiencing any of the following below, please circle: N/A

Nausea or vomiting Fainting or lightheadedness Headache or neck pain

Rapid eye movement Dizziness Difficulty swallowing Difficulty walking

Difficulty speaking Numbness on one side of the face or body Double vision

9) Are you Pregnant? (circle) Yes No If so how many weeks?_____ Due Date?_____

10) List current prescriptions or over the counter medications:

_____

11) List Vitamins/Herbs/Minerals/Supplements

_____

12) Please circle any of the conditions below if applicable: N/A

Cancer Heart disease Tumors HIV/AidsStroke Hernia

Diabetes Seizure Disorders Hepatitis High Blood Pressure Pacemaker Allergies

Previous Heart Attack Tuberculosis Osteoporosis Osteopenia Joint replacement

Fused Joints Arthritis Connective Tissue Disorder Lupus

Ehler Danlos Syndrome Marfan Syndrome Blood Disorder Rheumatoid Arthritis

Other: _____

13) Indicate if you have had any of the following:

Surgeries? (circle) Yes No If yes, what is the date and for what

_____

_____

Accidents/Traumas/Broken bones? (circle) Yes No If yes, what is the date and for what?

_____

_____

Hospitalizations? (circle) Yes No If yes, what is the date and for what?

_____

_____

14) Family History: (circle if applies) N/A

Cancer Stroke High Blood Pressure Heart Disease

Seizure Diabetes Connective Tissue Disorders Tumors

15) How did you hear about us?

_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital visits attributed to aspirin use from major GI events of the entire(upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self- administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Informed Consent to Care Signature

Patient Name: _____

Signature: _____

Date: _____

Parent or Guardian: _____

Signature:_____

Date: _____

Witness Name: _____

Signature:_____

Date: _____

CONFIDENTIALITY AND PRIVACY

Notice of Confidentiality and Privacy Practices

Our Obligations We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information
Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer. Please note that there may be a copy fee assessed.

In Clinic Operations: Chiropractic Adjustments will be performed in an open environment where other patients and or workers are present. Other persons may overhear protected medical information during treatment. If you need to talk with a Doctor in private, this will be accommodated upon request.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go

through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations:
As required by law. We will disclose Health Information when required to do so by international, federal, state, or If you have any questions about the above notice, please contact our Office at local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.
Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans: If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military. Workers Compensation. We may release Health Information for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.
Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We

may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations. Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights
You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer. Right to Amend. If you feel that Health Information we have 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 by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.
Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a 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 of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints
If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient name:_____

Signature: _____

Date: _____

Patient information

First Name: _____ Last Name: _____

Todays Date ____/____/____ Date of Birth: ____/____/____

Age: _____ Gender: (circle) Male Female

Phone number: _____

Email: _____ Contact Phone: _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Emergency Contact: _____ Phone number: _____

Are you Medicare Eligible? (circle one) Yes No

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? (circle one) Yes No

How far did you travel to get here today? _____

How long did it take to get here? _____

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Patient Activity Tool

First Name: _____ Last Name: _____

Work: _____

Occupation: _____ Age: _____

How do you perform your job? (circle one) seated standing both

How many hours per week do you work? _____

What body positions does your job require? _____

Do you wear orthotics? _____

What type of shoes do you wear on a daily basis? _____

Sleeping:

How many hours per night? _____

What position do you sleep in?(circle) Back Stomach Right Side Left Side

Type of bed you sleep on? _____

Activity:
Do you exercise?(circle) Yes No How often?(circle) 1x per week 2-3x per week

4-5x per week 2x per month 1x per month

What type of exercising/stretching? Strenuous Moderate Light None

Do you have children?(circle) Yes No How many? _____

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Cancellation and No Show Policy

There will be a fee if you are a no-show or fail to cancel or reschedule at least 24 hours before your scheduled appointment. We understand that life happens with emergencies and will accommodate. However, non-emergency cancellations made within 24 hours of your appointment will be considered a no show and billed accordingly.

If you are late, your appointment may not be extended and can be considered a no show.

This fee is patients' responsibility.

Patient Name: _____

Signature: _____

Date: _____

Parent or Guardian: _____

Signature: _____

Date: _____

Witness Name: _____

Signature: _____

Date: _____