The Official Provider For: USA Canoe/Kayak

Welcome to The League Chiropractic Clinic

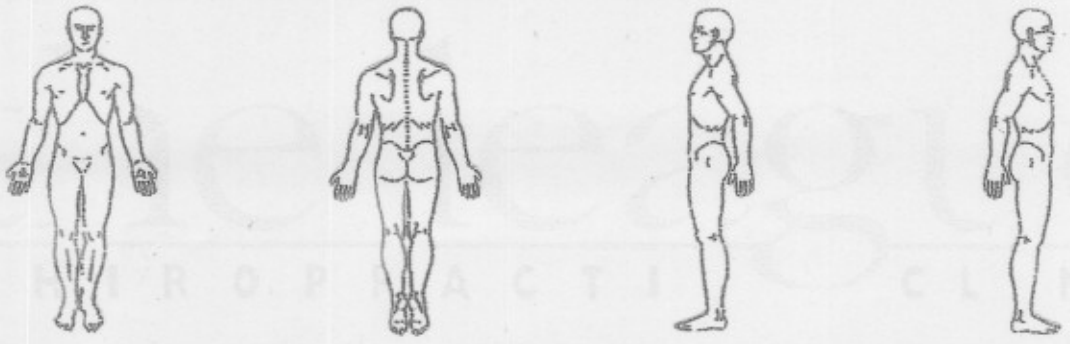
4510 Executive Dr. Plaza 5 San Diego, CA 92121
Phone: (858) 452-8888 E-mail: Info@TheLeagueChiropractic.com Fax: (858) 452-6666
www.TheLeagueChiropractic.com

Silver Sponsor Of: The Leukemia & Lymphoma Society TEAM IN TRAINING

New Patient Forms

Name: _____ Date: ___/___/_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
E-mail Address: _____
Social Security #: _____-_____-_____ Driver's License #: _____ Birthdate: ___/___/_____
Age: _____ Sex: **M** **F** Marital Status: **Married** **Single** **Widowed** **Divorced** No. of Children: _____
Occupation: _____ Employer: _____ Yrs. Employed: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Spouse's Name: _____ Occupation: _____ Employer: _____
Person Responsible For This Account: _____ Referred By: _____

Using The Body Charts Below, Please Circle All Affected Areas:



Reason For Today's Visit: **Emergency** **New Injury** **Old Injury** **Chronic Pain** **Wellness Visit**
What Is Your Primary Complaint: _____
Additional Complaint(s): _____
Are You In Pain Currently: **Yes** **No** Rate Your Level Of Pain: No Pain 1 2 3 4 5 6 7 8 9 10 Intense Pain
When did your injury occur: ___/___/_____ Where did your injury occur: _____
Please Explain What Happenened: _____
Is Your Condition Getting Worse? **Yes** **No** **Constant** **Comes & Goes**
Has This Or Something Similar Happened In The Past? **Yes** **No** If Yes, Please Explain: _____
Other Doctor's Seen For This Condition? **Medical Doctor** **Chiropractor** **Osteopath** **Accupuncturist** **Dentist**
Doctor's Name: _____ Diagnosis: _____ X-Rays Taken? **Yes** **No**
Treatment: **Medication** **Physical Therapy** **Surgery** **Adjustments** **Other:** _____

Have You Ever Been Treated By A Chiropractor? **Yes** **No** Dr's Name: _____
Are You Taking Any Medications? **Yes** **No** If Yes, What: _____
Are You Taking Non-Prescription Drugs? **Yes** **No** If Yes, What: _____
Do You Take Dietary Supplements Or Vitamins? **Yes** **No** If Yes, What: _____
Are You Wearing: **Heel Lifts** **OTC Insoles** **Custom Orthotics** **Other:** _____
List Surgical Operations and Dates: _____
List Any Past Serious Accidents With Dates: _____

Do You Have Group Or Personal Health Insurance? **Yes** **No** If So, Please Provide Your Card To The Receptionist

**Please Check Any Conditions Or Symptoms That Apply To You*

Family History
- ◊ Diabetes
- ◊ Thyroid Disease
- ◊ Tuberculosis
- ◊ Kidney Disease
- ◊ Liver Disease
- ◊ High Blood Pressure
- ◊ Heart Disease/Stroke
- ◊ Musculoskeletal Disease
- ◊ Cancer
- ◊ Other: _____

Endocrine System
- ◊ Heat/Cold Intolerance
- ◊ Thyroid Problems
- ◊ Diabetes
- ◊ Irradiation
- ◊ Hormone Replacement

Eye/Ear/Nose/Throat
- ◊ Visual Problems
- ◊ Pain In Eyes
- ◊ Difficulty Hearing
- ◊ Ringing In Ears
- ◊ Dizziness
- ◊ Ear pain
- ◊ Nosebleeds
- ◊ Inability to Smell
- ◊ Sinusitis
- ◊ Difficulty Swallowing
- ◊ Enlarged/Painful Glands
- ◊ Inability to Taste
- ◊ Dental Problems

Gastrointestinal System
- ◊ Change In Appetite
- ◊ Food Intolerances
- ◊ Nausea/Vomiting
- ◊ Indigestion/Heartburn
- ◊ Abdominal Pain
- ◊ Abdominal Swelling
- ◊ Gas

Gastrointestinal System (cont.)
- ◊ Change in Stool
- ◊ Diarrhea/Constipation
- ◊ Hernia
- ◊ Hemorrhoids
- ◊ Gallbladder Problems
- ◊ Liver Disease
- ◊ Pancreatitis

Respiratory System
- ◊ Difficulty Breathing
- ◊ Wheezing/Asthma
- ◊ Tuberculosis
- ◊ Pneumonia

Cardiovascular System
- ◊ Shortness of Breath
- ◊ Chest Pain
- ◊ Palpitations
- ◊ Edema/Swelling
- ◊ Fainting
- ◊ High Blood Pressure
- ◊ Heart Disease
- ◊ Rheumatic Fever
- ◊ Cardiovascular Surgery

Urinary System
- ◊ Frequent Urination
- ◊ Painful Urination
- ◊ Difficulty Starting
- ◊ Difficulty Holding
- ◊ Urinary Tract Infections
- ◊ Kidney Disease
- ◊ Flank/Pelvic Pain

Breasts
- ◊ Lumps
- ◊ Tenderness/Pain
- ◊ Pain Around Ribs

Reproductive System
- ◊ Genital Lesions
- ◊ Genital Pain
- ◊ Birth Control

◊ Hair/Skin/Nails
- ◊ Change in Skin Texture
- ◊ Skin Dryness/Wetness
- ◊ Rashes/Itching/Sores
- ◊ Mole Changes
- ◊ Skin Cancer
- ◊ Change In Hair
- ◊ Change in Finger/Toenails

Neurological System
- ◊ Headaches
- ◊ Seizures
- ◊ Dizziness/Fainting
- ◊ Sensation Disturbances
- ◊ Unusual Weakness
- ◊ Stroke

Psychological History
- ◊ Anxiety
- ◊ Depression

Musculoskeletal System
- ◊ Joint Pain
- ◊ Joint Swelling
- ◊ Muscle Weakness
- ◊ Neck Pain
- ◊ Mid Back Pain
- ◊ Low Back Pain
- ◊ Sacroiliac Pain
- ◊ Tailbone Pain
- ◊ Arm Problem
- ◊ Leg Problem
- ◊ Fracture/Dislocation
- ◊ Sprain/Strains

Female Patients Only
- ◊ Menstrual Irregularity
- ◊ Painful Cramping
- ◊ Premenstrual Syndrome
- ◊ Pregnant

Patient Information

Name: _____

Date: _____/_____/_____

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Notice Of Privacy - HIPAA

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

As your health care provider, we 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 & Payment Purposes

We may disclose your health care information to staff and other healthcare professionals within our practice for the purpose of consultation, treatment, payment, or healthcare operations. Additionally, we disclose your health information to your insurance provider(s), billing and insurance personnel, or a medical billing clearinghouse or collection agencies for the purpose of payment of your health care services. This office utilizes an outside billing service.

Workers' Compensation

We may disclose your health information as necessary to comply with state Work Comp Laws.

Emergencies

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

Other

As required by law, we may disclose your health information to the following persons or entities:

- Public Health Authorities
- Law Enforcement Officials
- Medical Examiners or Coroners
- Approved Medical Research or Review Board
- Public Safety Officials
- Specialized Government Agencies

Communications

We may contact you for additional communications, or other purposes, as described below:

It is our policy to call your home on the day prior to your scheduled appointment to remind you of your appointment time. A reminder message is left with a person or answering machine if you are not at home.

Birthday cards and/or seasonal greeting cards may be sent to your home periodically throughout the year, which may offer you a discounted or free service, a gift, or medical reminders. These greeting cards may be post cards and may not be enclosed in a sealed envelope. In the office, you may be asked to sign in and your name may be called out loud. If this is not desired, please tell the receptionist so alternative methods might be utilized to protect your privacy.

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Change of Ownership

In the event that this practice is sold or merged with another organization, your health record will become the property of the new owner

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that 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 a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If you 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 a right to receive an accounting of disclosures of your protected health information made by our office.
- You have a right to paper copy of this Notice of Privacy Practices at any time upon request.

Changes To This Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains.

We are required by law to maintain the privacy of your health information and to provide you with notice of our 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 office manager.

Complaints

Complaints about your Privacy Rights, or how our office handles the use or disclosure of your health information should be directed to our office manager.

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

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

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

Printed Name Of Patient: _____ Date: _____/_____/_____

Signature Of Patient: _____ Date: _____/_____/_____