HABERKORN CHIROPRACTIC

# New Patient Welcome Packet

Patient: _____ Date:_____
(first) (middle) (last)

□ Male □ Female □ Other _____ Birth Date: _____ □ Single □ Married □ Separated

Cell Phone: (___) _____-_____

Local Phone: (___) _____-_____ E-mail: _____

Local Address: _____
(street) (city) (state) (zip)

Home or Mailing Address: _____
(If different) (street) (city) (state) (zip)

Referred By: _____ Occupation: _____

Name of Spouse/partner: _____

Emergency Contact if different: _____ Phone (___) _____-_____

Name of Parent/Legal Guardian if patient is a minor: _____

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Haberkorn Chiropractic is NOT affiliated with any insurance network or plan. We do not accept insurance of any type and do not bill your insurance for you. We are happy to provide a receipt for services rendered which you may need for your taxes or if you choose to bill your insurance yourself.

Payment is due in full upon the conclusion of each visit. Payment may be in the form of cash, check, Visa, Mastercard, or Discover. I understand that I am responsible for paying for my visit at its conclusion. I choose to have treatment and accept these terms.

***Initial Here:*** _____

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Do you Have Medicare? Yes ____ No ____

If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorneys fees, and/or court costs will be added to the total amount due.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

SIGNED _____ DATE_____

RESPONSIBLE PARTY* _____ DATE_____

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HEAD:
- □ Headache
  - □ entire head
  - □ back of head
  - □ forehead
  - □ temples
  - □ migraine
- □ Head feels heavy
- □ Loss of memory
- □ Light-headedness
- □ Fainting
- □ Light bothers eyes
- □ Loss of smell
- □ Loss of taste
- □ Loss of balance
- □ Dizziness
- □ Loss of hearing
- □ Pain in ears
- □ Ringing in ears
- □ Buzzing in ears

NECK:
- o Pain in neck
- o Arthritis in neck
- o Neck pain with movement
- o Pinched nerve in neck
- o Neck feels out of place
- o Stiff neck
- o Muscle spasms in neck
- o Grinding sounds in neck
- o Grating sounds in neck
- o Popping sounds in neck

LOW BACK:
- o Low back pain
- o Low back pain Is worse when:
  - o working
  - o lifting
  - o stooping
  - o standing
  - o sitting
  - o bending
  - o coughing
- o Pinched nerve in low back
- o Slipped disc
- o Low back feels out of place
- o Muscle spasms
- o Arthritis

MID-BACK:
- o Mid-back pain
- o Pain between shoulder blades
- o Sharp stabbing pain In mid-back
- o Muscle spasms

ABDOMEN:
- o Nervous stomach
- o Nausea
- o Gas
- o Constipation
- o Diarrhea

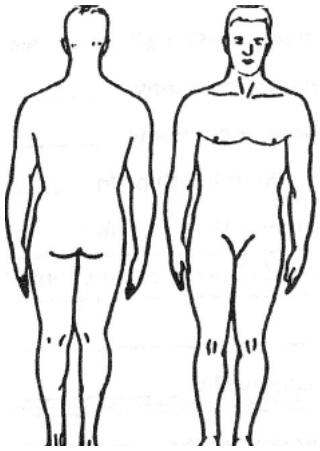
CHEST
- o Chest pain
- o Shortness of breath
- o Pain around ribs

SHOULDERS:
- o Pain in shoulder joint (R-L)
- o Pain across shoulders
- o Bursitis (R-L)
- o Arthritis (R-L)
- o Can't raise arm
  - o above shoulder level
  - o over head
- o ension in shoulders
- o Pinched nerve in shoulder (R-L)
- o Muscle spasms in shoulders

ARMS & HANDS:
- o Pain in upper arm
- o Pain in forearm
- o Pain In hands
- o Pain in fingers
- o Pinched nerve in arm
- o Pinched nerve in fingers
- o Sensation of pins & needles in arms
- o Sensation of pins & needles in fingers
- o Fingers go to sleep
- o Hands cold
- o Swollen joints in fingers
- o Sore joints in fingers
- o Arthritis in fingers
- o Loss of grip strength

HIPS, LEGS & FEET:
- o Pain in buttocks (R-L)
- o Pain in hip joint (R-L)
- o Pain down leg (R-L)
- o Pain down both legs
- o Leg cramps
- o Pins & needles in legs (R-L)
- o Numbness of leg (R-L)
- o Numbness of feet (R-L)
- o Numbness of toes
- o Feet feel cold
- o Cramps in feet (R-L)
- o Swollen ankles (R-L)
- o Swollen feet (R-L)
- o Painful joints In toes
- o Pain in foot (R-L)
- o Pain in knee (R-l)

GENERAL:
- o Depressed
- o Nervousness
- o Fatigue
- o Generally feel run-down
- o Loss of sleep
- o Loss of weight



**MARK AREAS OF PAIN ABOVE**

Have you had X-rays before? □ Yes □ No When?_____

What areas were x-rayed? _____

WOMEN ONLY: Date of last period:_____

□ Menstrual pain □ Cramping □ Irregularity > Pregnant? Yes □ No □ How far along_____

Purpose of this appointment:

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Date of accident/illness_____ Hour_____ AM PM Location:_____

How did accident occur? □ Auto Collision □ On-the-Job □ Other_____

Please describe the circumstances: _____

_____

Have you lost time from work? □ Yes □ No

Prior surgery: _____

Medications taken presently: _____

Previous accidents (other than described above) _____

Sleep Quantity _____hours Do you wake rested? _____

Stress 0-10 _____ Do you have and use stress reduction methods _____

Diet Type _____ Do you have a social support network? _____

HealthGoals_____

# INFORMED CONSENT-CHIROPRACTIC

**Please read this page. (Do not sign until after the Doctor has discussed this with you)**

PATIENT NAME: _____ DATE: _____

Chiropractors have been providing great health care services to patients for more than 100 years. Many patients with acute and chronic spine-related and extremity disorders and joint stiffness, arm and leg complaints, and other musculoskeletal conditions or injuries have benefited by having chiropractic care. In order for said chiropractor (see below) to determine what types of treatment may be beneficial to you, it is necessary to perform a physical examination of your spine and other joints. Identifying subluxations or abnormal joint function is achieved by looking at x-rays and/or during the examination which involves moving various joint(s) or areas of your body in specific directions to determine how well each of the painful or restricted joints or bony structures of your body moves or is positioned when compared to the normal population. Spinal manipulation, a procedure that involves the application of controlled mechanical forces to specific joint structures, has the goal of improving and restoring normal joint motion of the spine and other joints. Better bone and joint alignment and motion improves the function and health of the joint, associated muscles and nerves and thus reduces inflammation and related symptoms. After treatment, most of our patients experience increased flexibility, feel less pain and other symptoms, and are able to return to their normal physical activities at work and home. The goal of chiropractic care is to improve and normalize the quality of joint motion in the affected areas of your body, to encourage you to adopt good lifestyle habits such as exercise and good nutrition, and assist you during the recovery process.

Rejecting chiropractic care may lead to progression of joint restrictions, stiffness, pain and other symptoms and may compromise your ability to perform activities at home and work. There are various types of non-chiropractic treatment available for patients who have your type of condition(s), including; acupuncture, physical therapy, or from a medical doctor or other health care provider.

While uncommon, some patients may experience short-term increase of pain and other symptoms or muscle and ligaments strains or sprains as a result of manipulation and manual therapy techniques such as joint mobilization or deep massage. There are some rare potential serious bodily harm risks to chiropractic manipulations and procedures to various regions of the body, including, but not limited to, strains, sprains, fractures, disc injuries, dislocations, strokes, and nerve injuries.

Strokes are a very rare event in the general population and have been reported after patients visit chiropractors or primary care providers (medical doctors). Scientific evidence shows that the increased stroke risks are likely due to patients seeking care from chiropractors or medical doctors because of an unusual type or severity of headache and neck pain. These symptoms are from an early stroke that is already occurring and progressing from prior damage to an artery in the neck. Once seen by a doctor, the risk of the stroke progressing has been found in the literature to be similar (no excessive risk) for patients who are seen by chiropractors and primary care providers. There is scientific evidence that shows that patients who have these developing strokes may have weakened or diseased artery vessel walls that are particularly vulnerable to a variety of motions or movements of the neck and head or they may occur spontaneously without any known reason. Research has shown that there are many stroke risk factors, including: disease of blood vessels, high blood pressure, birth control pills, environmental and genetic factors, infections, occurring during falls, violent car accidents, coughing/sneezing, sport activities, or even during such trivial movements as turning ones head to back up a car or to paint a ceiling. The literature shows that there are rare risks of strokes specifically from rotating and extending the head and neck during cervical spine manipulation or other maneuvers that rotate or extend the head and neck, particularly the upper cervical spine. You are being informed of this reported association because a stroke may cause serious injury or even death.

I voluntarily consent to the performance of chiropractic examination, manipulation and other chiropractic procedures, on myself, (or on the patient named below, for whom I am legally responsible) by said chiropractor (see below), his/her preceptor(s), and/or other licensed doctors of chiropractic who now or in the future provide chiropractic treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for said chiropractor, whether or not their names are listed on this form. I understand that the results from the chiropractic treatment are not guaranteed for my condition. The doctor has verbally discussed the goals and potential benefits of the proposed treatment, other alternative types of treatment for my condition and the associated risks by having chiropractic examination, manipulation, and other procedures. I have had the opportunity to read this form and understand the above statements, accept the risks mentioned, and hereby consent and agree to the recommended chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment

_____ _____

DR SIGNATURE: CONSENT WAS DISCUSSED VERBALLY. DR SIGNATURE: PATIENT WAS ASKED “DO YOU UNDERSTAND?”

**X**_____

**SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

NAME: _____ RELATIONSHIP: _____

Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor):

# NOTICE OF PRIVACY PRACTICES (HIPPA)

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.

Haberkorn Chiropractic is 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 health operations.

**Payment:** We may disclose your health information to your Insurance provider for the purpose of payment.

**Workers' Compensation:** We may disclose your health information to the 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 in the event of an emergency or of your death.

**Public Health:** By law, we 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 & Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administrative Proceedings:** We disclose your health information in the course of any administrative or judicial proceedings and your health information to law enforcement official for purposes such as identifying a suspect, fugitive, material witness or missing person, complying with a court order 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 & transplanting organs.

**Public Safety:** It may be necessary to disclose your health information to appropriate persons in order to 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 disclose your health information for military, national security, prisoner and government benefits purposes.

**Communication:** As a courtesy to our patients, we may 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 will leave a reminder message on your answering machine. No personal health information will be disclosed during this recording.

**Change of Ownership:** In the event that Haberkorn Chiropractic is sold or merged with another organization; your health information will become the property of the new owner.

**Your Health Information Rights:**

- -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 Haberkorn Chiropractic amend your protected health information. Please be advised, however, that Haberkorn 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 Haberkorn Chiropractic.
- -You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Haberkorn Chiropractic reserves 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. Haberkorn Chiropractic is required by law to comply with this Notice and 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 any questions about any part of this notice or if you want more information about your privacy rights, please contact Dr. Robert W. Haberkorn D.C. by calling (760) 346-9400. Complaints about your Privacy rights, or how Haberkorn Chiropractic has handled your health information should be directed to Dr. Robert W. Haberkorn D.C.. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DIUIS, Office of Civil Rights, 200 Independence Avenue, Washington DC 20201.

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

By way of my signature, I provide Haberkorn 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 Signature Date

_____ _____

Authorized Facility Signature Date