CHIROPRACTIC NEUROLOGY CENTER

Dr. Shad J. Groves, DC, DACNB | Dr. Karin Kim, DC

HEALTH HISTORY FORM

Name: _____ **Today's Date:** _____

Address: _____ **City/State:** _____

ZIP: _____ **Cell number:** _____

Email: _____ **Referred by:** _____

Date of Birth: _____ **Allergies:** _____

Sports & activities: _____

Current medications: _____

MEDICAL HISTORY

Are you under medical care for any of the following? Name of Primary Care Physician: _____

- ☐ heart conditions
- ☐ high/low blood pressure
- ☐ fainting or dizziness
- ☐ varicose veins
- ☐ phlebitis/circulatory problems
- ☐ headaches or migraine
- ☐ neck injury
- ☐ back injury
- ☐ jaw or ear pain
- ☐ osteoporosis
- ☐ rheumatoid arthritis
- ☐ osteoarthritis
- ☐ cancer
- ☐ kidney disease
- ☐ skin conditions
- ☐ diabetes
- ☐ asthma/respiratory
- ☐ fibromyalgia
- ☐ Crohn's disease
- ☐ pelvic inflammatory disease
- ☐ epilepsy
- ☐ nervous disorders
- ☐ Whiplash
- ☐ other:

Have you received care from any of the following? (circle):

☐ Physiotherapist ☐ Chiropractor ☐ Massage Therapist ☐ Naturopath

Other: _____

Reason for treatment: _____

Number/duration of treatments: _____

Have you had surgery in the past? ☐ Y ☐ N If yes, what/where? _____

Have you had any fractures/sprains in the past? ☐ Y ☐ N If yes, what/where? _____

Have you had any serious illnesses in the past? ☐ Y ☐ N If yes, what/where? _____

Have you had any of the following regarding your current condition? (circle)

☐ Physician's examination ☐ x-ray ☐ other diagnostic tests

What relieves your pain? _____

What aggravates your pain? _____

Signature of Patient (or Guardian): _____

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INFORMED CONSENT TO MASSAGE THERAPY TREATMENT

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the California Massage Therapy Association.

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes. I understand that such treatment is guided by a chiropractor and any questions I have about my massage will be discussed by my massage therapist with a chiropractor.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my chiropractor and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the chiropractor and the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

I acknowledge that Chiropractic Neurology Center located at 1225 E Wardlow Rd, Long Beach, CA 90807, has offered/presented me with a copy of their privacy practices. This notice explains how my protected health information (PHI) may be used and what Chiropractic Neurology Center's responsibilities are regarding my privacy rights. I have been provided a copy of the privacy practices.

Patient Name: _____ **Signature of Patient/Guardian:** _____

Witness: _____ **Date Signed:** _____

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EMERGENCY CONTACTS AND COMMUNICATION AUTHORIZATION

If you have an emergency whom may we contact? Please list the name, address, phone number, and relationship of the individual listed.

EMERGENCY CONTACT NO. 1

Name: _____ **Phone:** _____

Address: _____

Relationship: _____

EMERGENCY CONTACT NO. 2

Name: _____ **Phone:** _____

Address: _____

Relationship: _____

AUTHORIZATION TO VERBALLY COMMUNICATE WITH A FAMILY MEMBER/FRIEND

Our office is required by the Federal HIPAA laws to have you sign whether you desire to have your PHI discussed with a family member or friend. If you authorize our office to speak with a family member or friend, please indicate the name of the person, relationship to you and what may be discussed. If you have any aspects of your PHI that you do not want disclosed, please list the specific aspects of your PHI below that you wanted "restricted." This authorization may be revoked by you at any time, by advising our office (privacy officer) of this revocation in writing. If you choose to not sign this authorization, this will not have any adverse effects on your treatment, eligibility for benefits, enrollment, or payment.

☐ Yes, I authorize verbal communication with the following person(s):

Contact No. 1: _____ **Relationship:** _____

Telephone No.: _____

PHI Restrictions: _____

Contact No. 2: _____ **Relationship:** _____

Telephone No.: _____

PHI Restrictions: _____

Patient Signature: _____ **Date:** _____

Expiration Date/Event for authorization: _____ ☐ NO expiration date.