

# PATIENT INTRODUCTION FORM

Today's Date: \_\_\_\_\_

<b>Last Name:</b> _____		<b>MI:</b> _____	<b>First Name:</b> _____	
<b>Home Address:</b> _____		<b>City:</b> _____	<b>State:</b> _____	<b>Zip:</b> _____
Date Birth: _____	Age: _____	Telephone: Home: _____		Office: _____
Height: _____	Weight: _____	Who Referred You to Our Office: _____		
Employer's Name: _____		Marital Status (Circle): Single, Married, Divorced, Widowed		
Occupation: _____		Name of Family Physician: _____		

**Email Address:** \_\_\_\_\_

<p>The Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws. Patient confidentiality and privacy/security applies to any <b>protected health information (PHI)</b>.</p> <p>Signature: _____ Date: _____</p> <p>Expiration Date/Event for Authorization:  <input type="checkbox"/> No expiration date  <input type="checkbox"/> When treatment has concluded and bills have been paid.  <input type="checkbox"/> Date: _____</p>	<p style="text-align: center;"><b>PRIVACY NOTICE-HIPAA.</b></p> <p>I acknowledge that the office, has presented me with a copy of the privacy practices and I have been able to read the practice policies notice that is posted on the waiting room wall. This notice explains how my protected health information (PHI) may be used and what the office responsibilities are regarding my privacy rights. I have been allowed to request a printed sheet of the office's privacy notice. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.</p>
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**IS THIS VISIT RELATED TO:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Work Related Injury/Symptoms | <input type="checkbox"/> Motorcycle-Bicycle Injury  | <input type="checkbox"/> Non-Injury Pain/Symptoms |
| <input type="checkbox"/> Sport or Recreational Injury | <input type="checkbox"/> Home Injury Symptoms       | <input type="checkbox"/> Check-up Only            |
| <input type="checkbox"/> Motor Vehicle Crash Injury   | <input type="checkbox"/> School/Employment Physical | <input type="checkbox"/> Other (Describe): _____  |

**HEALTH-MEDICAL INSURANCE INFORMATION**

Does your insurance plan cover Chiropractic treatment?	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, we need a copy of the card
If yes, indicate Insurance Company Name (Need copy of card).	Insurance Name: _____ Address: _____ Telephone: _____
Are you the insured person or dependent (wife/husband/child)?	<input type="checkbox"/> Insured, <input type="checkbox"/> Dependent
If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number, and the company/business name of the insured employer in order to do billing.	Name of Insured Person: _____ Social Security Number: _____ Insured Date of Birth: _____ Name of Insured Employer: _____
What is your co-payment amount for each visit?	Amount: \$ _____ Percentage: %
Do you have a health insurance deductible for chiropractic?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Deductible \$ _____ Have you met deductible yet?
Specific chiropractic health insurance benefits	Number visits per year # _____. Amount per year: \$ _____

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies): \_\_\_\_\_

**OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES FOR AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS.**

Patient Signature and Date	I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health/automobile insurance carrier. Minors must have parent's signature.
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Doctor's Name/Address: Dr. Dhesi, FCG Healthcare, 1081 Market Place, Suite 100, San Ramon, CA 94583

# GENERAL HEALTH HISTORY

*Check only those conditions that apply to you and indicate if you have had in the past or presently have.*

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	History of poor healing or told that you have a healing disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of any disease such as AIDS, Tuberculosis, ALS, Meningitis, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history or any other neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or cancer treatment or surgery of any type?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected mild strokes or transient ischemic attacks)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have a bulging/herniated disc or disc degeneration in the spine?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why/When:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension or high blood pressure? If yes, name of MD seeing:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Autoimmune disease, Crohn's disease, ulcerative colitis, muscle diseases, etc?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Do you have any type of chest or breast implants presently (males &amp; females)?</b>	N/A	<input type="checkbox"/>
<input type="checkbox"/>	<b>Women only:</b> Check box to left if there any chance that you are currently pregnant		

## PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

**I have no history of previous painful injury or pain** If you have had prior injuries or pain, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Home/Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car Accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> arm numb/tingling	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Leg Pain/Tingling	<input type="checkbox"/> Other Pain:	

## FRACTURES/BROKEN BONES HISTORY

**I have never had any broken bones.** If you have broken/fractured any bones, indicate where and when below:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone, ribs, or sternum		<input type="checkbox"/> Pelvis or hip bones	
<input type="checkbox"/> Arm, leg, hand, or foot bones		<input type="checkbox"/> Other: List	

## PREVIOUS SURGERIES

**I have never had any surgical procedure.** If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck, back, or pelvis)		<input type="checkbox"/> Abdominal/chest Surgery or Appendix	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Liver/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Head/Brain/Spinal Cord/Nerve		<input type="checkbox"/> Hernia (inguinal or hiatal)	
<input type="checkbox"/> Shoulder/Arm/Hip/Leg		<input type="checkbox"/> Other	

When did you have your last physical examination by a medical doctor? Year: \_\_\_\_\_ Name MD: \_\_\_\_\_

Patient Name:	Doctor's Name:
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## GENERAL HEALTH HISTORY (Page 2)

No,  Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, spinal cord, brain, nerves, or other diseases? If yes, please describe: \_\_\_\_\_

No,  Yes **Have you ever been to a Chiropractor before for any condition?**

If yes, Chiropractor's Name/City : \_\_\_\_\_ Year: \_\_\_\_\_

List Problem(s) that the Chiropractor treated you for: \_\_\_\_\_

No,  Yes **Do you have any problems laying face down on an examination table**, including tender chest/breast, level of pain, etc? If yes, why: \_\_\_\_\_

### LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, or Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, or Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, or Tingling		<input type="checkbox"/> Other:	

**Did your current symptoms come on?**  Suddenly,  Gradually

### ARE YOU TAKING ANY MEDICATIONS PRESENTLY?

**I am not taking any medications currently.** Check any of the following that you are taking currently.

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Blood pressure or Stroke prevention medications	<input type="checkbox"/> Endocrine-Hormone medications
<input type="checkbox"/> Pain/Anti-inflammatory meds	<input type="checkbox"/> Osteoporosis (bone strengthening) medications	<input type="checkbox"/> Other:
<input type="checkbox"/> Diabetic medications	<input type="checkbox"/> Immunity drugs	<input type="checkbox"/> Other:

### WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

<input type="checkbox"/> Morning is when pain is worse	<input type="checkbox"/> Bending your back increases pain	<input type="checkbox"/> Walking increases pain
<input type="checkbox"/> Afternoon/evening pain worse	<input type="checkbox"/> Lying down flat increases pain	<input type="checkbox"/> Standing increases pain
<input type="checkbox"/> During sleep hours pain worse	<input type="checkbox"/> Sitting increases pain	<input type="checkbox"/> Exercise/Stretching increases pain
<input type="checkbox"/> Standing up from sitting	<input type="checkbox"/> Poor posture increases pain	<input type="checkbox"/> Other:

### WHAT ACTIVITIES LESSEN YOUR PAIN?

<input type="checkbox"/> Walking	<input type="checkbox"/> Being flat on your back	<input type="checkbox"/> Exercise/Stretching
<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Other:

### DO YOU EXERCISE?

<input type="checkbox"/> I do no regular exercise	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/home	<input type="checkbox"/> I do cardiovascular work outs
<input type="checkbox"/> I am willing to do exercise	<input type="checkbox"/> I am not willing to do exercises	<input type="checkbox"/> I do regular sports activities

### HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Kidney pain/painful urination	<input type="checkbox"/> Balance problems

Patient Name:	Doctor's Name:
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Form 1010