Jason Amstutz DC, CCSP,CSCS
Frank Acunia DC, MPT
Kenneth Dobbs DC
Andrew Adams DC

Intake Form

Patient Name: _____ Today's Date: _____

Address: _____ Home #: _____

_____ Work #: _____

E-mail: _____ Cell #: _____

Gender: Male / Female Birth Date: ___ / ___ / ___ Age: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____ Dominant Hand: Right / Left

Who may we thank for referring you? _____

Parent/Guardian (If patient is under 18 years of age)

Name: _____

Home #:_____ Cell #:_____

Work #: _____

Emergency Contact:

Name: _____

Home #: _____ Cell #: _____

Information regarding today's visit

Reason for visit today? _____

Have you ever had a concussion? Yes or No

Was this injury a result of a Motor Vehicle Accident? Yes or No

Was this a work related injury? Yes or No

If you have pain/problems currently, where is your pain/problem? (Check all that apply)

[ ] Back [ ] Hip [ ] Thigh [ ] Knee [ ] Lower Leg [ ] Ankle/Foot [ ] Neck [ ] Shoulder

[ ] Upper Arm [ ] Elbow [ ] Forearm [ ] Wrist/Hand

When did this current episode of pain/your problem begin? _____

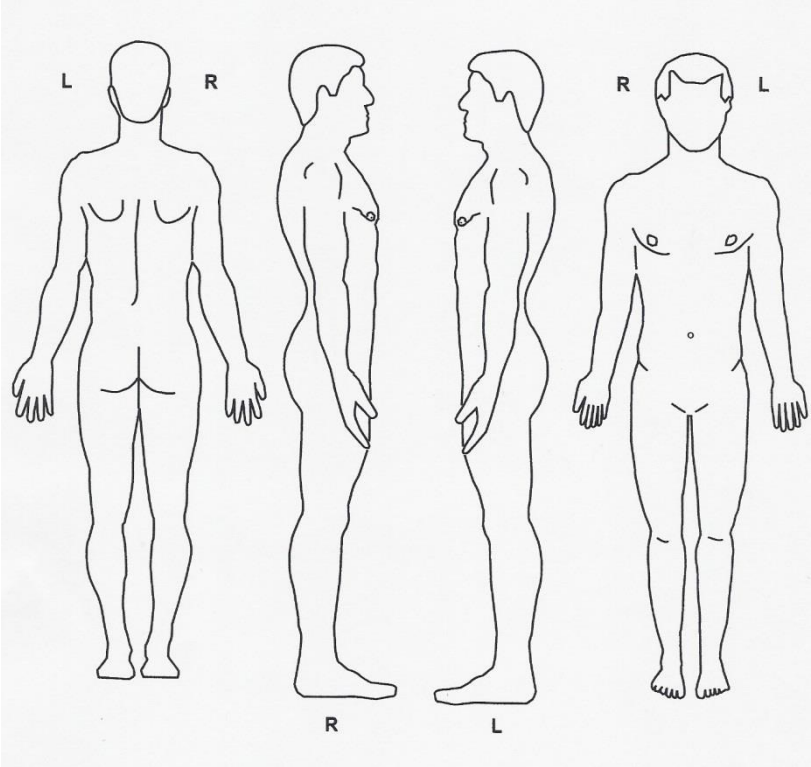
Did the pain/problem begin: [ ] gradually [ ] suddenly

How did this episode of pain begin (check all that apply)? [ ] Bending [ ] Lifting [ ] Twisting [ ] A Fall

[ ] Pushing/Pulling [ ] Other _____ [ ] Accident; date occurred: _____

Please use the diagram and symbols to indicate where your pain is.

Aching = AAA Burning = XXX Numbness = OOO Pins/Needles =..... Stabbing/Sharp = ///



If you have back pain *with* leg pain or neck pain *with* arm pain, please answer the following:

Do you ever have your back or neck pain *without* your leg or arm pain? [ ] No [ ] Yes

What percent of your total pain is in your back or neck and what percent is in your leg or arm? (Both numbers should add up to 100%): Back or Neck ____% Leg or Arm ___%

Please check the activities that affect the pain or your problem.

	Better	Worse	No Change		Better	Worse	No Change
Cough/Sneeze	[ ]	[ ]	[ ]	Bending Forward	[ ]	[ ]	[ ]
Straining	[ ]	[ ]	[ ]	Bending Backward	[ ]	[ ]	[ ]
Standing	[ ]	[ ]	[ ]	Walking	[ ]	[ ]	[ ]
Sitting	[ ]	[ ]	[ ]	Reaching Overhead	[ ]	[ ]	[ ]
Lifting	[ ]	[ ]	[ ]	Squatting	[ ]	[ ]	[ ]
Pushing/Pulling	[ ]	[ ]	[ ]	Kneeling	[ ]	[ ]	[ ]
Driving	[ ]	[ ]	[ ]	Typing / Writing	[ ]	[ ]	[ ]
During Activity	[ ]	[ ]	[ ]	After Activity	[ ]	[ ]	[ ]
Running	[ ]	[ ]	[ ]	Biking	[ ]	[ ]	[ ]
Eating	[ ]	[ ]	[ ]	Other_____	[ ]	[ ]	[ ]

Is your pain/problem [ ] Intermittent or [ ] Constant

How many days per week or months per year do you typically have your pain/problem? _____

How much of the time during an average day do you have your pain/problem?

[ ] < 1 hour [ ] 1-4 hours [ ] 4-8 hours [ ] Almost 24 hours [ ] Whenever I'm not resting

How long *without a break* have you had your current pain/problem?

[ ] < 2 weeks [ ] 2-6 weeks [ ] 6-12 weeks [ ] 3-6 months [ ] > 6 months

Mark an "X" for the WORST and an "O" for the best time of the day for your pain/problem.

[ ] Getting out of Bed [ ] Morning [ ] Mid-day [ ] Evening [ ] Nighttime

How often does your pain limit your quality of sleep? [ ] Never [ ] Often [ ] Always

Do you regularly curtail or miss social activities because of your pain/problem? [ ] Yes [ ] No

Have you ever had an ER visit or Hospital admission because of your pain/problem? [ ] Yes [ ] No Please circle the number that best represents your pain (0 being none, 10 being unbearable).

At its BEST?	0	1	2	3	4	5	6	7	8	9	10
At its WORST?	0	1	2	3	4	5	6	7	8	9	10
TODAY?	0	1	2	3	4	5	6	7	8	9	10

Treatment History for this pain/problem

List the physicians and chiropractors that you have seen for this pain/problem

Doctor's name	Specialty	Location	Approximate Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Which of the following tests or treatments have been done for your pain/problem.

	No	Yes	Date	What area of Body/Results
X-rays	[ ]	[ ]	_____	_____
Bone Scan	[ ]	[ ]	_____	_____
MRI	[ ]	[ ]	_____	_____
CT Scan	[ ]	[ ]	_____	_____
Myelogram	[ ]	[ ]	_____	_____
EMG / NCS	[ ]	[ ]	_____	_____
Discogram	[ ]	[ ]	_____	_____
Epidural Injection	[ ]	[ ]	_____	_____
Joint Injection	[ ]	[ ]	_____	_____

Other [ ] [ ] _____

Please place a check next to the type of treatment you received and how it affected your pain/problem.

	Yes	Helped	No Effect	Made Worse
Hot Packs / Ultrasound	[ ]	[ ]	[ ]	[ ]
Ice / Cold Treatments	[ ]	[ ]	[ ]	[ ]
Massage / Myofascial release	[ ]	[ ]	[ ]	[ ]
Traction	[ ]	[ ]	[ ]	[ ]
TENS unit	[ ]	[ ]	[ ]	[ ]
	Yes	Helped	No Effect	Made Worse
Muscle Stimulator	[ ]	[ ]	[ ]	[ ]
Chiropractic adjustments	[ ]	[ ]	[ ]	[ ]
Acupuncture	[ ]	[ ]	[ ]	[ ]
Bracing / Splinting	[ ]	[ ]	[ ]	[ ]
Strengthening Exercises	[ ]	[ ]	[ ]	[ ]
Stretching exercises / Yoga	[ ]	[ ]	[ ]	[ ]
Homeotherapy	[ ]	[ ]	[ ]	[ ]

If you had surgery for this or any other problem, complete the following for each operation.

Surgery Type/ Date	Worse/Same/Better	Length of Time/Type of Improvement

Other information you think we should know about your pain/problem?

_____

_____

Review of Systems

Please check off any symptoms you are currently experiencing.

[ ] Fevers/Chills	[ ] Chest Pain/Tightness	[ ] Night Sweats	[ ] Shortness of Breath
[ ] Anxiety	[ ] Persistent Cough	[ ] Leg Swelling	[ ] Stiff Joints
[ ] Depression	[ ] Excessive Fatigue	[ ] Painful urination	[ ] Joint Swelling/warmth
[ ] Difficulty swallowing	[ ] Unusual Skin Rash	[ ] Easy Bruising	[ ] Unexplained Weight Loss
[ ] Menstrual problems	[ ] Black or Bloody Stools	[ ] Loss of Bowel or Bladder Control	

[ ] Difficulty Sleeping [ ] Unusual Stress in Home Life [ ]
Unusual Stress in Work Lift [ ] Unusual bumps/lumps

Medical History

Please check if you have had or are currently having problems with any of these illnesses.

[ ] Stroke	[ ] Thyroid problems	[ ] Depression	[ ] Osteoporosis
[ ] Current infection	[ ] Anxiety	[ ] Heart Disease	[ ] Osteoarthritis
[ ] Gout	[ ] Lupus	[ ] Cancer	[ ] Diabetes type _____
[ ] High Blood Pressure	[ ] High Cholesterol	[ ] Possibly could be pregnant	
[ ] Stomach or Intestinal Ulcers		[ ] Rheumatoid Arthritis	

[ ] Others _____

Previous injuries

Date of Injury	Injury:	Treating Doctor:	Outcome:

Please list all old injuries; include date of injury, treatment, treating doctor, and current status of injury:

Medications/Supplements

Current medications (prescription or over-the-counter):

Name	Dosage	Why?	How long?

Current Dietary Supplements or Vitamins:

Name	Dosage	Why?	How long?

Medication Allergies/Sensitivities: [ ] No known medication allergies

Name	What happens if you take this medication?	

Family History

Please check if anyone in your immediate family has had or are currently having problems with any of these illnesses.

[ ] Stroke [ ] Thyroid problems [ ] Depression [ ] Osteoporosis
[ ] Current infection [ ] Anxiety [ ] Heart Disease [ ] Osteoarthritis
[ ] Gout [ ] Lupus [ ] Cancer [ ] Diabetes type_____
[ ] High Blood Pressure [ ] High Cholesterol [ ] Rheumatoid Arthritis [ ] Stomach or Intestinal Ulcers
[ ] Others _____

Current/Past Exercise Programs and Goals

Please list all training programs you have partaken in the last 3 years. Include a short description of activities completed.

Program Name: Description:

_____ _____

_____ _____

_____ _____

Are you currently performing any regular physical exercise? Please describe:

Type of activity?	1.	2.	3.
How frequently?			
Intensity (high, medium, low)?			
How long (duration)?			

Goals

What are your goals for the following categories? Please list them below and rank your first three goals in order of importance with '1' being your primary goal.

Rank	Category	Goals
	Health	
	Fitness	
	Conditioning	
	Sports/Performance	

If you could choose a goal to accomplish in the next 90 days with your health and fitness what would it be? Please be detailed and specific.

_____
_____
_____
_____

Stress and Sleep Cycle

Circle the current level of stress you are experiencing on a scale of 1 to 10:

1 2 3 4 5 6 7 8 9 10

very low very high

Identify the major cause of stress (e.g. changes in job, work, residence, finances etc):

_____

_____

_____

Do you have a difficult time falling asleep? Yes / No

Do you tend to wake during the night? Yes / No

If yes, please circle when: 11 pm – 1 am

1 am – 3 am

3 am – 5 am

Are you a slow starter in the morning? Yes / No

Your blood type (please circle): O A B AB

Food/Dietary

Known or suspected food allergies/sensitivities:

___ Bananas ___ Dairy ___ Tomatoes ___ Corn ___ Chocolate

___ Strawberries ___ Eggs ___ Eggplant ___ Wheat ___ Refined sugars

___ Citrus Fruits ___ Soy ___ Peppers ___ Peanuts ___ Gluten foods (all)

___ Sulfites ___ Shellfish Other: _____

Vegetarian intolerances or foods you have chosen to eliminate from your diet:

___ Red Meat ___ Poultry ___ Fish ___ Dairy ___ Eggs ___ Other: _____

For the following questions, check the most accurate answer for you:

	Infrequently	Occasionally	Almost every day
I eat fresh fruit:	[ ]	[ ]	[ ]
I eat leafy vegetables:	[ ]	[ ]	[ ]
I eat other vegetables (beans, peas, etc.):	[ ]	[ ]	[ ]
I consume sugars, syrup, candy and soft drinks:	[ ]	[ ]	[ ]
I consume artificial sweeteners:	[ ]	[ ]	[ ]
At the table, I salt my food:	[ ]	[ ]	[ ]

The meats I eat are mainly:	The dairy products I eat are mostly:
___ High fat (hamburger, prime beef) ___ Medium fat (lean beef, chicken with skin) ___ Lean (fish, skinless chicken/turkey)	___ Full fat ___ Low fat/skim ___ I don't eat dairy

The wheat, rice, pasta and other grains I eat are mostly:	With fats such as margarine, butter, mayonnaise, salad dressings and oils, I:
___ Highly processed, bleached white ___ Medium processed, enriched ___ Coarse ground, whole grain	___ Seldom control intake ___ Occasionally watch quality/quantity ___ Always watch quality/quantity

I eat fried foods, including most fast foods: [ ]Often [ ]Occasionally [ ]Seldom (1x/week or less)

How many glasses of water do you drink per day?: _____

What is the source (tap, well, filtered, bottled, etc.)?: _____

How many cups of coffee do you drink daily (caffeinated/decaffeinated)? _____	How many cups of tea, or glasses of iced tea do you drink daily?
If you use sweetener what type do you use? _	How many glasses of sodas do you drink per week? _____

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HIPAA Disclaimer: Notice of Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

You r Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Uses and Disclosures of Health Information We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation and certification, licensing or credentialing activities.

To You or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with a n opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose you r health information to assist in disaster relief efforts.

Marketing Health-Related Services: W e will not use your health information f or marketing communications without your written authorization.

HIPAA continue:

Required by law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers ' compensation or similar programs .

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Access: You have the right to look at or get copies of your health information, with limited except ions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0._ for each page,$0 per hour for staff time to copy your health information, and postage costs if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a compliant with us or with the U.S. Department of Health and Human Services.

Financial Consent

The well being of our patients is our primary concern and our goal is to provide excellent care to everyone who seeks our services. Part of maintaining a good physician-patient relationship is advising you in advance of office policies related to our practice. Please read this page carefully and indicate your agreement by signing below. If you have any questions, please do not hesitate to ask a member of our staff.

- ✓ On arrival, please let the front desk know you are here and sign in.
- ✓ It is your responsibility to provide the office with a copy of your insurance card, legal identification card and notify the office of any changes to your insurance coverage.
- ✓ It is your responsibility to provide the office with true and correct information regarding your current or previous conditions as the doctor relies on the information to render care. You further agree that all information provided to the treating physicians is true and correct and you are not attempting to injure, defraud or deceive your insurance company.
- ✓ We require that all patients maintain a valid credit card on file with us. Any patient balances that are present after 30 days from the date of invoicing will be automatically billed on your credit card.
- ✓ You are responsible for any and all co-payments, deductibles, coinsurances, out of network balances and services not covered by your insurance at the time of your visit. We collect an estimated amount upon each visit and any balance amounts deemed your financial responsibility would be billed and are payable by you. Patient/Guardian initial here: ____.
- ✓ While we verify your insurance coverage as a courtesy, it is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
- ✓ Payment for all SoCal Med Group, Inc. services is the responsibility of the patient and is either due at the time of your visit or upon presentation of our invoice. As in and out-of-network medical providers, SCMG participates in some private or government sponsored insurance plans. We will, as a courtesy, submit insurance claims for services provided to most commercial insurance companies on our patients' behalf with the exception of out of network plans managed by A.S.H.. Medicare patients are encouraged to seek reimbursement for these services directly from Medicare. We will provide Form 1490S (SC) – Patient's Request for Medical Payment, as well as all information related to treatment required by Medicare.
- ✓ If you have no insurance, covered by Cigna (ASH) or the service provided is not covered by your plan **(i.e. cold laser, trigenics [myoneural], active release therapy, phone consultations)**, payment for the service(s) is to be paid at the time of the visit.
- ✓ Patient balances are billed upon receipt of your insurance plan's Explanation of Benefits (EOB). There are however, some plans which do not send SCMG any information related to patients' EOBs. Patients' with those plans will be billed immediately following their visit. Your remittance is due within 10 business days from the date of our invoice.

- ✓ If we do not receive payment the balance will be placed on your credit card. If your credit card is not valid, any balance over 60 days will be forwarded to a collection agency. Unpaid account balances that are more than thirty (30) days past due, shall accrue interest at the rate of eighteen (18%) percent per year on any and all past due amount. In the event that your account is sent out for collection, you will be liable for all reasonable attorney fees and expenses.

- ✓ Not all services provided by our office are covered by every plan. Any service or amounts determined to not be covered by your plan will be your responsibility.

- ✓ We require a 24-hour notice for cancelling any appointments. We reserve the right to assess a $50 charge for missed medical appointments if the time cannot be filled by another patient.

- ✓ A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Print Patient's Name: _____

Signature: _____ Date: ___ /___ /___

Signature of Guardian (If patient is under 18 years of age): _____

Acknowledgement of Receipt of Notice of Privacy Practices

(Provided to you at the time of appointment)

-You may refuse to sign this form.-

I, have received and read a copy of SoCal Med Group, Inc.'s Notice of Privacy Practices.

Signature: _____ Date: _____

Guardian Signature (if patient is under 18 years): _____

----------FOR OFFICE USE ONLY----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained due to:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement ¨ Other (specified below)

Notes:

_____

_____

_____

_____

Frank Acunia DC, MPT Jason, Amstutz DC, CCSP, CSCS Kenneth Dobbs DC Andrew Adams DC
351 Hospital Road, Suite 007 Newport Beach CA 92663 Phone: 949-465-0770

INFORMED CONSENT WAIVER AND AUTHORIZATION TO TREAT

I, _____, hereby request and consent to the performance of pain management, chiropractic and/or physical medicine services by the doctor(s) named below.

I understand and am informed that in the practice of pain management, chiropractic or physical medicine there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels is in my best interest.

I understand that under California Proposition 65 there may be some toxins or chemicals I may be exposed to either in the treating environment, supplements purchased or therapies/treatments provided with California has deemed potentially harmful to my family or me. I understand I may view the full Prop 65 list by visiting: http://oehha.ca.gov/prop65/prop65_list/Newlist.HTML and agree I will not hold LINK Medical Center responsible for any claim or damages as a result of any exposure.

I have read the above consent and intend this form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment at SoCal Med. Group, Inc.

Print Patient's Name: _____

Signature:_____ Date: ___ / ___ /___

Signature of Guardian (if patient is under 18 years): _____