Intake Form

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home # _____ Cell #_____ Work # _____

Email: _____

Gender: M / F Birthdate: _____ / _____ / _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____

Dominant Hand: R / L

Who may we thank for referring you? _____

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

Name: _____

Home # _____ Cell # _____

Work # _____

Emergency Contact:

Name: _____

Relation: _____ Cell # _____

Information Regarding Visit:

Reason for this appointment: _____

_____

_____

_____

When did this issue begin? _____

Was there an event surrounding the issue (i.e. accident/event)? _____

Have you been given a diagnosis? Yes / No If so, what? _____

What kinds of treatment have you tried? _____

Have they helped alleviate the condition/problem? Yes / No

Are you currently receiving treatment? Yes / No If so, please describe: _____

List any other problems/concerns: _____

_____

_____

ALLERGIES:

Drug allergies (penicillin, etc.):

_____

Allergies to foods, pollen, etc.:

_____

MEDICAL STATUS

General health: ☐Excellent ☐Good ☐Fair ☐Poor Height: _____ Weight: _____

Current medications (vitamins, prescriptions, herbal, or otherwise):

Medication	Date Started	Date Stopped	Dosage	# Per Day

Past medication use:

	Infancy	Childhood	Teens	Adulthood
Antibiotics				
Steroids				

Who is your Primary Care Physician? _____

Have you seen a physician for any reason in the past 3 months? If so, for what? _____

_____

Have you had blood work in the past 3 months? Yes / No Was it normal? Yes / No

If abnormal, please describe: _____

_____

_____

List any other health care providers: _____

MEDICAL HISTORY

Illnesses: _____

_____

Significant trauma (i.e. motor vehicle accident, falls, etc.): _____

_____

Broken bones or dislocations: _____

_____

X-Ray, MRI, CAT, or Bone Scans (where and when), what was found? _____

_____

Do you have or have you ever had any infectious diseases? Recurring infections? Yes / No

Please describe: _____

How many times each year do you have a Cold, Sinusitis, the Flu, Sore Throat, Bronchitis? _____

How long do they usually last, and are they severe? _____

What do you feel your weakest organ system is? (i.e. heart, kidney, liver, lungs, etc.) _____

_____

HOSPITALIZATIONS/OPERATIONS

Date	Diagnosis	Surgery	Outcome

SYMPTOMS CHECKLIST:

Circle those you presently have (during the last few weeks), and **underline** those you've had previously.

GENERAL
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Imbalance
Seizures
Epilepsy
Sleeping difficulties
Quality of sleep: ___
Sleep: ___ hrs/nt
Feel run down
Fatigue
Hypoglycemic
Nervousness/anxiety
Panic attacks/phobias
Depression
On anti-depressants
Mental disorder
Alcohol problems
Drug problems
Diabetes
Neuralgia
Anemia
Cancer
Memory loss
Scarlet fever
Rheumatic fever
Measles
Mumps
Chicken pox
Weight loss: ___ lbs.
Weight gain: ___ lbs.
Other: _____

EAR, NOSE, THROAT
Eye strain/pain
Failing vision
Blurred vision
Glaucoma
Sensitive to light
Hearing problems
Ear ringing/noises
Ear discharge
Sinus infection
Nose bleeds
Nasal obstruction
Nasal drainage
Sore throat
Hoarseness
Loss of voice
Dental decay
Mouth sores
Gum disease
Teeth grinding
Jaw pain
Frequent colds
Thyroid condition
Tonsillitis
Enlarged Glands
Hay fever
Other: _____
Gout

SKIN
Rashes
Skin eruptions
Eczema
Itching
Bruise easily
Dry skin
Boils
Moles
Varicose vein
Sensitive skin
Hair loss
Other: _____

RESPIRATORY
Asthma
Allergies
Pneumonia
Emphysema
Tuberculosis
Bronchitis
Pleurisy
Chronic cough
Spitting blood
Spitting phlegm
Chest pain
Difficulty of breathing
Shortness of breath
Other: _____

CARDIOVASCULAR
Rapid heartbeat
Slow heartbeat
Irregular heartbeat
High blood pressure
Blood clots
Low blood pressure
Pain over heart
Pacemaker
Hardening of arteries
Ankle swelling
Poor circulation
Stroke/TIA
Other: _____

MUSCLE & JOINT
Stiff neck
Back pain
Parasites
Swollen joints
Painful joints
Arthritis
Bursitis
Tendonitis
Muscle/joint weakness
Muscle spasms/cramps
Foot trouble
Spinal curvature
Osteoporosis
Other: _____

GENITOURINARY
Frequent urination
Night urination: ___ times
Painful urination
Blood in urine
Pus in urine
Kidney infections or stones
Bed-wetting
Inability to control urine
Prostate trouble
Hernia
Sexually transmitted disease
Sexual dysfunction/difficulty
Other: _____

GASTROINTESTINAL
Trouble swallowing
Bad breath
Indigestion/heartburn
Nausea
Poor appetite
Belching/Gas
Excessive hunger
Cravings
Eating disorder
Vomit blood
Stomach pain
Cramping pain
Ulcers
Abdomen distention
Constipation
Diarrhea
Colitis/IBS
Appendicitis
Hemorrhoids
Intestinal worms

Hepatitis
Liver problems
Gallbladder problems
Jaundice
Bad body odor
Other: _____

PAIN ASSESMENT:

Did your pain or symptoms come on gradually or suddenly? _____ Is it constant? Yes / No

What time of day is the pain the worst? Morning, Afternoon, Evening, Night

What make the symptoms worst? _____

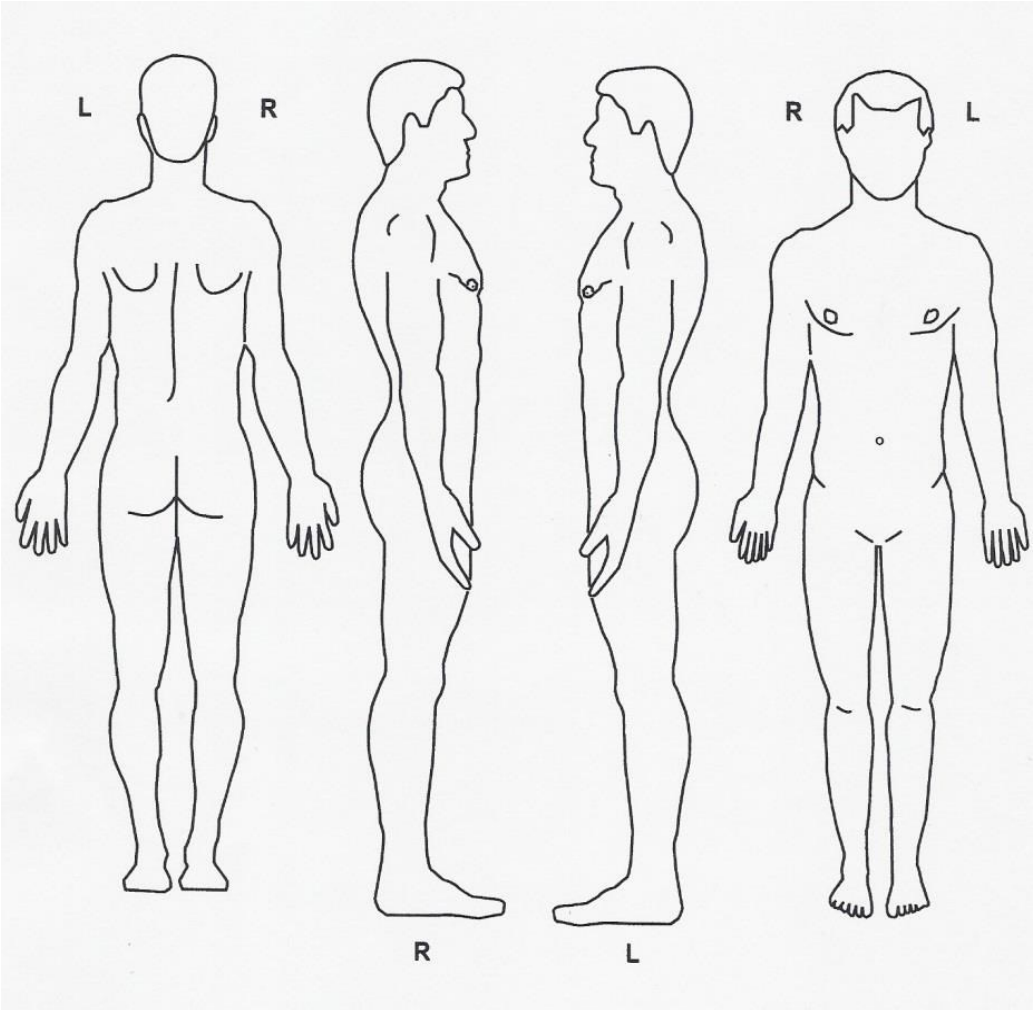
What makes the pain or symptoms better? _____

PATIENT PAIN DRAWING

Please place the symbol(s) on the body in the area(s) that best describes the pain or discomfort you have.

Aching = AAA Burning = XXX Numbness = 000 Pins/needles = … Stabbing/ Sharp = ///

On a scale of 0-10 with 0 being pain-free and 10 being constant, disabling pain, rate each area of pain.



Other than the health concerns you already have indicated, which of the following would you additionally like our support? (Mark all that apply)

☐Have more energy/vitality	☐Slow down accelerated aging	☐Be happier
☐Sleep better	☐Monitor my body's aging	☐Be less depressed
☐Be less tired after lunch	☐Maintain a healthier life longer	☐Not so many drugs
☐Get less colds and flus	☐Be stronger	☐Be less moody
☐Get rid of allergies	☐Reduce body fat	☐Think more clearly
☐Have more sex drive	☐Be more flexible	☐Improve my memory
☐Reduce risk of degenerative disease	☐Improve my skin quality	☐Reduce stress

DIETARY PREFERENCES

Sample of day's menu:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Dietary restrictions: _____

What allergies to foods, drugs, or inhalants are you aware of, and how do you react? _____

_____

HABITS

Water: Glasses per day of: Tap _____ Bottled _____ Filtered _____

Alcohol: _____ glasses of wine/wk. _____ glasses of beer/wk.

Liquor: _____ ounces/wk.

Caffeine: Cups per day of: Coffee _____ Tea _____

Soda w/ caffeine: _____ cans/day Soda w/o caffeine: _____ cans/day

Chocolate or other sweets: How much per day or week? _____

Cigarettes: #/day _____ Previously? Yes / No How much? _____ How long? _____

Other tobacco: #/day _____ Previously? Yes / No How much? _____ How long? _____

Mood altering substance use (i.e. marijuana, cocaine, past & present): _____

Exposed to 2nd hand smoke or pollution? _____ Previously? _____ How much? _____ How long? _____

Chemicals at work? Yes / No Previously? Yes / No How much? _____ How long? _____

Do you have your teeth cleaned regularly? Yes / No Do you floss your teeth regularly? Yes / No

How many times a day/week do you have bowel movements? _____ times per day / week

Are your bowel movements loose, hard, difficult to pass, strong smelling, accompanied by gas? (circle all that apply) What is the typical color? Black, brown, clay, or greenish Ever bloody? Yes / No

On a scale of 1-10, what number do you believe reflects your current level of stress? _____

Please list the 3 most significant stressful events in your life: _____

_____

Please indicate those continuing to impact your life: _____

_____

FAMILY HISTORY

Member	Living?	Age	Major diseases*	Cause of death and age
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal Grandma				
Maternal Grandpa				
Paternal Grandma				
Paternal Grandpa				

*alcoholism, high blood pressure, cancer, diabetes, heart disease, arthritis, asthma, allergies, depression, other illness

FOR MEN ONLY

Please check or explain if applicable.

☐Reduced sexual desire _____

☐Premature ejaculation _____

☐Seminal emission _____

☐Impotence _____

☐Painful or dribbling urine _____

☐Pain associated with genitals _____

FOR WOMEN ONLY

☐Irregular periods ☐Painful periods ☐PMS ☐Light flow ☐Heavy flow

☐Clots ☐Vaginal discharge ☐Endometriosis ☐PCOS ☐Ovarian cysts

☐Uterine fibroids ☐Pelvic surgery

Breasts: ☐Pain/tenderness ☐Lumps ☐Cysts ☐Discharge ☐Fibroids

Date last period began: _____ Date prior period began: _____

Age of first menstrual cycle: _____ Age/date of last menstrual cycle: _____

Uterus/ovaries still in tact? Yes / No If no, date removed and why? _____

Have you reached menopause? Yes / No List symptoms you are experiencing: _____

Date of last pap smear/pelvic exam: _____ Pap normal? Yes / No

Have you ever had an abnormal pap? Yes / No When? _____ Results: _____ Treatment: _____

Are you sexually active? Yes / No Do you practice safe sex? Yes / No

Birth control methods (current and past): _____

Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Normally (not on pills) the number of days from the start of one period to the start of the next? _____

Number of days of flow: _____ Amount of bleeding: _____ Amount of cramps: _____

Color of blood (i.e. bright red/purplish/dark red): _____ Clots? Yes / No

Premenstrual symptoms: _____ Starting when? _____

Any current changes in your normal pattern? _____

Any bleeding between periods? Yes / No When? _____

Unusual vaginal discharge or itching? Yes / No How long? _____Past treatment? _____

Any sexual concerns to discuss? _____ History of tubal infection? Yes / No

Any past history of sexually transmitted diseases? _____

Other/additional comments: _____

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.

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:

_____

_____

_____

_____

_____

361 Hospital Road, Suite 428 Newport Beach, CA 92663 Phone: 949-465-0770
Mailing: P. O. Box 15096 Newport Beach, CA 92659

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):

_____

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 canceling any appointments. We reserve the right to assess a charge from $50 to full prices for missed medical appointments..

- ✓ 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): _____

Credit Card On File Authorization Form

Please complete this form if you would like LINK Medical Center to keep your credit card on file for future transactions. The use of this form is optional and for your convenience. You may elect to provide us payment information each transaction if you do not wish us to use your credit card on file.

The undersigned agrees and authorizes LINK Medical Center to charge the credit card indicated below for any account balances.

Client's Name: _____

Name as it Appears
on the Credit Card: _____

Type of Credit Card: ☐MasterCard ☐Visa ☐Discover ☐AMEX

Card Number: _____

Expiration Date: _____ (month/year) Zip Code: _____

Security Code: _____

I, _____ authorize LINK Medical Center to process the above credit card as "Signature on File" for any balance due on my account. I understand this authorization with expire upon conclusion of care.

Card Holder Signature *Date*