Welcome to Our Office

PATIENT INFORMATION

Name _____ Date (first appointment) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Birth Date _____ Age _____ Sex: M F Marital Status M S W D Number of Children _____

Occupation _____ Employer _____ Yrs Employed _____

Work Phone _____ ☐ Yes, please text me for appointment reminders

How did you hear about us? _____ Do you have insurance? Yes ☐ No ☐

Emergency Contact# / Relationship _____ (If you have an insurance card, please give it to the staff to copy)

FOR WOMEN

Are you pregnant? Yes ☐ No ☐ Date of last menstrual period _____ Sex of Baby _____

If pregnant, congratulations! How many weeks? _____ Your estimated due date: _____

Where will you be birthing your baby? Home☐ Birthing Center☐ Hospital☐ Other ☐_____

Name of OBGYN or Midwife: _____

PATIENT'S CONDITION

Reason for seeking chiropractic care_____

_____

Have you ever been under chiropractic care before? Yes☐ No☐ When was your last visit? _____

Name of previous chiropractor: _____ How long under care? _____

CHECK ANY THAT APPLY:

HEAD
- ☐ Headache
  - ☐entire head
  - ☐back of head
  - ☐forehead
  - ☐temples
  - ☐migraine
- ☐Head feels heavy
- ☐Loss of memory
- ☐Light-headedness
- ☐Fainting
- ☐Sensitivity to light
- ☐Loss of smell
- ☐Loss of taste
- ☐Loss of hearing
- ☐Pain in ears
- ☐Ringing/buzzing in ears
- ☐Dizziness

NECK
- ☐Pain in neck
- ☐Neck pain with movement
- ☐Stiff neck
- ☐Muscles spasms in neck
- ☐Grinding/popping sounds in neck

SHOULDERS, ARMS, HANDS
- ☐Pain in shoulder (R or L)
- ☐Can't raise arm (R or L)
  - ☐above shoulder level
  - ☐over head
- ☐Pain in upper arm (R or L)
- ☐Pain in forearm/wrist (R or L)
- ☐Pain in hands/fingers (R or L)
- ☐"Pins & needles" in arms/hands/fingers
- ☐Numbness in arms/hands (R or L)
- ☐Cold hands (R or L)
- ☐Swollen/sore joint in fingers (R or L)
- ☐Weak grip strength (R or L)

MID BACK
- ☐Mid back pain
- ☐Pain between shoulder blades
- ☐Mid back stiffness

ABDOMEN
- ☐Nervous stomach
- ☐Nausea
- ☐Gas
- ☐Constipation
- ☐Diarrhea
- ☐Vomiting

LOW BACK
- ☐Low back pain
  - Worse when:
  - ☐standing
  - ☐sitting
  - ☐laying down
  - ☐lifting
  - ☐bending
  - ☐coughing
- ☐Low back feels out of place
- ☐Muscle spasms
- ☐Stiffness

HIPS, LEGS & FEET
- ☐Pain in buttocks (R or L)
- ☐Pain in hip joint (R or L)
- ☐Pain down leg (R or L)
- ☐Leg cramps (R or L)
- ☐Sensation of pins & needles in legs
- ☐Pain in knee (R or L)
- ☐Pain in foot (R or L)
- ☐Numbness of legs/feet/toes (R or L)
- ☐Feet feel cold (R or L)
- ☐Cramps in feet (R or L)
- ☐Swollen ankles/feet (R or L)

CHEST
- ☐Chest pain
- ☐Shortness of breath
- ☐Pain around ribs
- ☐Chronic cough
- ☐Acid reflux
- ☐Irregular heartbeat

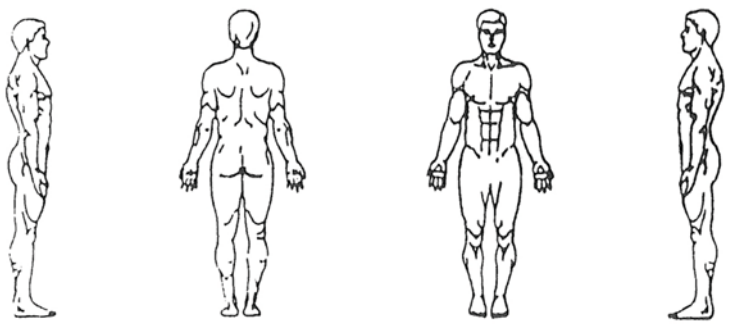
GENERAL
- ☐Anxiousness
- ☐Irritable
- ☐Depressed
- ☐Fatigue/chronic tiredness
- ☐Loss of sleep
- ☐Loss of weight
- ☐Loss of concentration

CONDITIONS
- ☐High Blood Pressure
- ☐Cancer
- ☐Diabetes
- ☐Stroke
- ☐Overweight/Obese
- ☐OTHER_____
- ☐OTHER _____

If you have pain, how severe is it? (circle) 0 1 2 3 4 5 6 7 8 9 10

None Unbearable

Please mark X on the body diagram where you have problems



Physical Stress

List childhood illnesses (asthma, chicken pox, etc.) -

_____

Have you been in any accidents? Yes☐ No☐ If yes, describe_____

Do you play any sports? Yes☐ No☐ If yes, describe_____

Have you fallen/slipped/had a concussion? Yes☐ No☐ If yes, describe_____

Have you had any surgeries? Yes☐ No☐ If yes, describe_____

Other _____

Emotional Stress

Childhood Trauma Yes☐ No☐ Loss of loved one Yes☐ No☐ Abuse Yes☐ No☐

Work or School Yes☐ No☐ Divorce/Relational Yes☐ No☐ Financial Yes☐ No☐

Lifestyle change Yes☐ No☐ Family issue/Parents' divorce Yes☐ No☐ Illness Yes☐ No☐

Other _____

Chemical Stress

Were you vaccinated? Yes☐ No☐ If yes, did you have any adverse reactions? Yes☐ No☐

Was there any prolonged use of medications such as antibiotics, steroids or inhalers as a child? Yes☐ No☐

If yes, describe _____

Do you smoke cigarettes, cigars, cannabis? Yes☐ No☐ Other☐ How often? _____

Have you been exposed to any of the following toxic chemicals?

Second-hand smoke☐ Prolonged drug therapy☐ Radiation☐ Chemotherapy☐ Other☐_____

Do you have allergies? Yes☐ No☐ To what? _____

Do you consume any of the following presently?

Coffee☐ Alcohol☐ Tobacco☐ Over-the-counter medicine☐ Prescription medicine☐ Soda(regular☐/diet☐)

Please list all medications you take

_____

FAMILY HEALTH PROFILE

Your family's health is relevant and important to us. Please describe the health of your family/relatives.

Mother_____

Father_____

Siblings_____

Spouse_____

Children_____

QUALITY OF LIFE

Mark X on the line where you believe your state of health is.

Poor Fair Good Excellent Optimal

How much water do you drink a day? _____

Do you exercise? Yes☐ No☐ Do you have access to a gym/health club? Yes☐ No☐

What does your exercise routine look like, if any?_____

Do you take vitamins/supplements? Yes☐ No☐ List:

_____

How many hours do you watch TV and use a computer/electronic device per day? _____

CERTIFICATION OF FACTS/FINANCIAL AGREEMENT

By signing below I certify that the above information is correct to the best of my knowledge. I understand that I am financially responsible for my care. If I have insurance, I authorize payment of benefits to Dr. Cassandra Sepulveda and authorize the release of any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurances and non-covered services.

Patient's Signature_____ Date_____

Informed Consent Form Chiropractic

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common [1, 2]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [3, 4]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome [(2)] (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have every felt[(3)]

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery[5].
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition[6]

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine.* Oct 1 2007;32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther.* Jul-Aug 2007;30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008;33(4 Suppl):S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008;33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S75-82.

PLEASE DO NOT SIGN THIS FORM UNTIL AFTER YOUR TREATMENT PLAN HAS BEEN REVIEWED WITH YOU BY YOUR DOCTOR

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	DOCTOR'S COMMENTS
GENERAL		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	
Have you been diagnosed with a compression fracture(s) of the spine?	☐	
Have you ever been diagnosed with cancer?	☐	
Do you have any metal implants?	☐	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	☐	
If yes, about how much do you take daily? _____		
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?	☐	
Have you ever been diagnosed with any of the following disorders/diseases?		
• **Rheumatoid arthritis**	☐	
• **Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis**	☐	
• **Giant cell arteritis (temporal arteritis)**	☐	
• **Osteogenesis imperfecta**	☐	
• **Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome**	☐	
• **Medial cystic necrosis (cystic mucoid degeneration)**	☐	
• **Bechet's disease**	☐	
• **Fibromuscular dysplasia**	☐	
Have you ever become dizzy or lost consciousness when turning your head?	☐	
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	☐	
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	☐	
Have you been diagnosed with spondyliolithesis?	☐	
Have you had any of the following problems?		
• **Sudden weakness in the arms or legs?**	☐	
• **Numbness in the genital area?**	☐	
• **Recent inability to urinate or lack of control when urinating?**	☐	

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT [or PARENT/GUARDIAN] SIGNATURE _____ **DATE** _____

INTERN SIGNATURE _____ **DATE** _____

DOCTOR'S SIGNATURE _____ **DATE** _____

arcadia health chiropractic
DR. CASSANDRA SEPULVEDA INC.

AHC OFFICE POLICIES & PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Arcadia Health Chiropractic for your health care needs. We are honored by your choice and are committed to providing you with the highest quality of care.
We ask that you take a moment to thoroughly read and sign this form to acknowledge your understanding of our office policies and financial agreement which are as follows:

FINANCIAL AGREEMENT

- The patient is ultimately fully responsible for the payment of all charges or fees for services provided, regardless of any contract of insurance, any action at the court, any settlement, structured settlement, verdict, or arbitration award which may be received or be due, or the course of outcome of any dispute regarding the same.
- The patient is aware that failure to pay for his/her treatment and care will result in the collection actions being taken to collect debt (i.e. being sent to collections agency)
- The patient is responsible for any costs associated with the collection of patient balances
- The office charges a $30 fee for non-sufficient funds for returned checks.
- PrePaid packages expire 12 months from the date of purchase and are non-refundable/non-transferable. Any remaining balance on your plan after this time can be credited towards regular visits at the current pricing schedule.

INITIAL _____

NEW PATIENT APPOINTMENTS
All new patient appointments require a $100 deposit to reserve your appointment. This deposit will then be applied to your first visit. Failure to cancel or reschedule this appointment with at least a 24 hour notice will result in a loss of this deposit.

INITIAL _____

SCHEDULING APPOINTMENTS
Please respect our time and let us know at least 24-hours in advance if it is necessary to reschedule your appointment – we may have other patients who would like to schedule an appointment during your original time slot. Our office staff usually sends appointment reminders whenever possible as a *courtesy*, however it remains ***your responsibility*** to remember your appointment day and time in event you do not receive a reminder.

INITIAL _____

LATE CANCELLATION/NO SHOW FEES
Failure to contact us at least 24 hours in advance to cancel/reschedule your appointment will result in the ***full cost*** of your appointment that will be due on your next visit. If you are under a pre-paid treatment plan, one visit will be deducted from your plan.

INITIAL _____

LATE APPOINTMENT ARRIVALS
If you are running more than ten minutes late to your appointment, please contact us as it may be possible that your office visit will be shorter than normal or need to be rescheduled. Dr. Sepulveda may be able to see you in the remaining time only if it does not compromise the quality of your care or another patient's appointment time.

INITIAL _____

I, (print name)_____understand and agree to the terms of this policy.

_____ _____
Signature **Date**