Rebalance Chiropractic
Dr. Chris Meanley
230 Second St. Ste 101
Encinitas, CA 92024

rebalancet3@gmail.com
rebalancechiropractic.com
(760) 632-0098

NEW PATIENT HEALTH INFORMATION

Today's date: ___________________________ ☐ Male ☐ Female Birth date: _____/_____/__________

Name: ________________________________ What do you prefer to be called: ________________________

Home address: ____

Phone #: ______________________________ E-mail: ____

Referred by: ____________________________ Occupation: ____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's name: ____

In the event of emergency, who should we contact?: ______________________ Relation: _____________________

Phone #: ________________________________

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No

If so, please explain: ____

The reason for this visit is a result of: ☐ Work ☐ Sports ☐ Auto ☐ Trauma or Chronic

Explain what happened: ____

Please describe the pain and its location: ____

When did the condition begin? __________________________________

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine

If so, please explain: ____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: ____

Have you been treated by a medical physician for this condition? ☐ Yes ☐ No

If so, where? ____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at time of visit.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any insurance coding for insurance purposes that I, as the patient would submit to insurance.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: ____ Date: _________________

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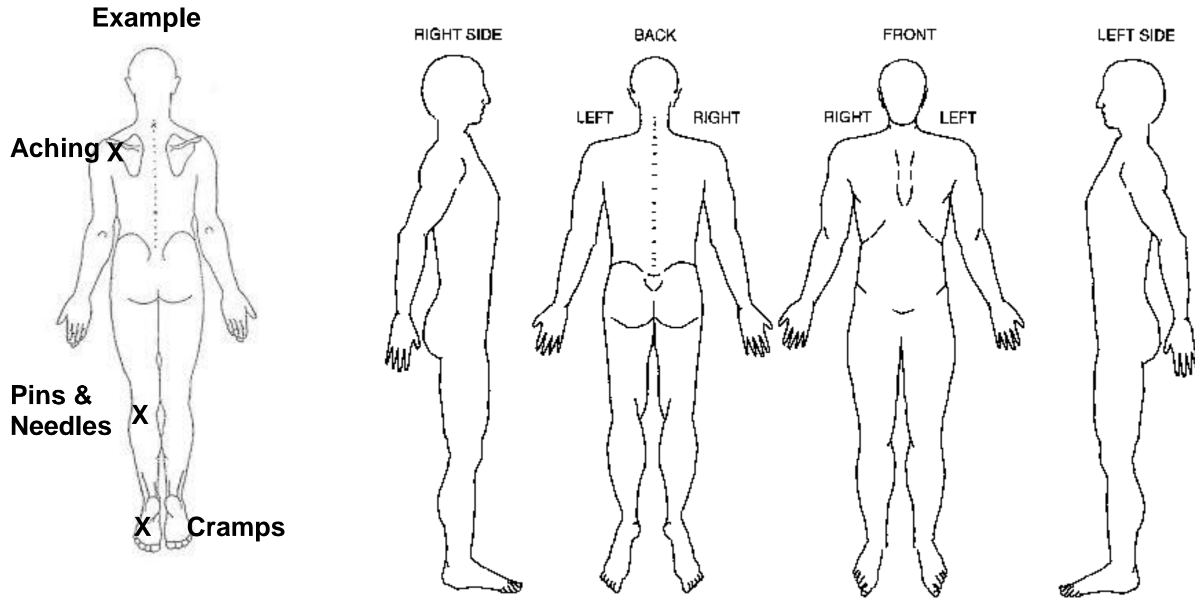
PAIN CHART

Name: ______________________________________ Date: __________________

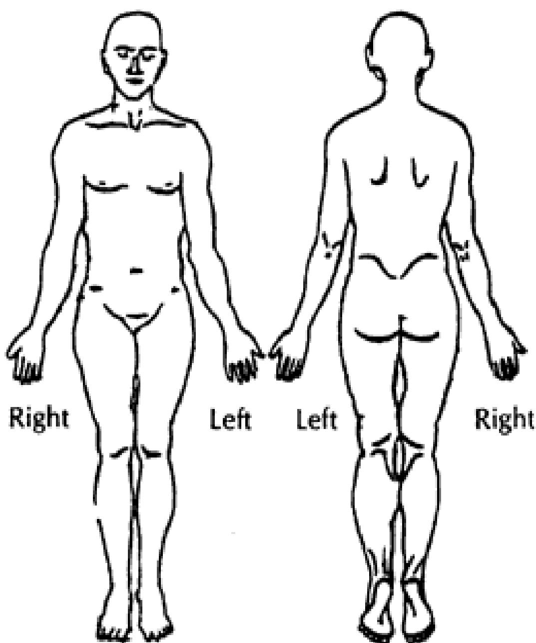
Please mark area(s) of pain or discomfort as shown below in the example and describe (ex. numbness, pins & needles, burning, aching, stabbing, cramps.) Write anywhere in this area.



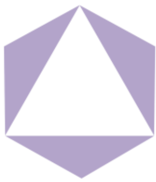
Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain)

1 2 3 4 5 6 7 8 9 10

Please mark all places that have ever been injured: Sprains/Strains, broken bones, severe bruises, surgery, scars, head bumps, cuts, burns, etc.



What happened?	When did it happen?



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CONFIDENTIAL HEALTH HISTORY

Name: ____ Date:_________________

Height: _______________ Weight: ______________Children (list ages and sex):
____

Please check the appropriate box for any of the following symptoms:

(Columns: OCCASSIONAL / FREQUENT)

GENERAL
- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or Fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot Trouble
- ☐ ☐ Low back pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen Joints

RESPIRATORY
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

GASTRO-INTESTINAL
- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult Digesting
- ☐ ☐ Gall Bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE & THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ear noise
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of the arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Swelling of ankles

SKIN
- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

Genito-Urinary
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inability to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstruation
- ☐ ☐ Vaginal discharge

Pregnant ☐ Yes ☐ No
Date of last period ___________
Previous miscarriages ☐ Yes ☐ No

Check off conditions that **family members experience and write relationship to family member:**

☐ Aids	☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Pneumonia	☐ Tuberculosis
☐ Alcoholism	☐ Chicken Pox	☐ Foot problems	☐ Measles	☐ Polio	☐ Typhoid fever
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Multiple Sclerosis	☐ Rheumatic fever	☐ Ulcers
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Mumps	☐ Scarlet fever	☐ Venereal disease
☐ Arteriosclerosis	☐ Emphysema	☐ Heart disease	☐ Pacemaker	☐ Stroke	

DATE OF LAST: (Approx.)
________ Physical examination
________ Blood Test
________ General X-Ray
________ MRI

None	Light	Moderate	Heavy	
☐	☐	☐	☐	Alcohol
☐	☐	☐	☐	Coffee
☐	☐	☐	☐	Tobacco
☐	☐	☐	☐	Drugs
☐	☐	☐	☐	Exercise
☐	☐	☐	☐	Soft drinks

Have you ever:
- ☐ Been knocked unconscious?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for any other reason other than surgery?
- ☐ Had surgery? (list below)
- ☐ Had a root canal? Date_____________

____

Please list any prescription drugs now taking and allergies____
____

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Signature: _______________________________________ Date: __________________

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OFFICE POLICIES AND PROCEDURES

Welcome to the office of Dr. Chris Meanley. As one of our patients, we would like to inform you of our current procedures and policies.

Procedures: We proudly operate a low volume chiropractic practice. This enables us to provide a greater range of services beyond spinal manipulation and unattended modalities such as: Active Release, Clinical Kinesiology, Neuro Emotional Technique, Contact Reflex Analysis, Quantum neurology and other procedures. These techniques help you get better faster and corrections that are done last longer than only spinal manipulation and physical therapy. My time is my resource that I want to make available to you. In that time, I use your direction and my clinical judgment to determine what techniques to use in a plan designed to help you reach your health goals.

Appointment Policies: Our policy is that if you need to reschedule your appointment, please allow a 24 hour notification prior to your appointment time. Without the 24 hour notice or a no show you will be charged a fee for 50% of the visit. New Patients who book a 1 hour appointment are required to give a CC# to reserve their appointment.

Insurance: Although we do not accept insurance we will gladly provide a superbill for you to submit to your insurance.

Please keep in mind that some circumstances can throw Dr. Meanley behind schedule. Measures are taken throughout the day to keep the doctor on schedule and we appreciate your understanding in this matter.

Thank you for your cooperation and consideration!

Signature____ Date__________________________

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INFORMED CONSENT

I, the undersigned, have voluntarily requested that Dr. Meanley D.C. assist me in the management of my health concerns. I understand that Dr. Meanley, D.C. is a chiropractor and that his services are not to be construed or serve as a substitute for standard medical care. Dr. Meanley D.C. recommends that I undergo regular routine medical check-up by my medical doctor.

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, ___________________________________, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustment including the movement of the joints and soft tissues. Physical therapeutics, home exercises, and nutritional supplements/dietary recommendations may also be used.

Routine chiropractic examination and treatment include some of the following methods:

- Observation: general assessment/appraisal in all postures.
- Inspection: Viewing/looking at your body regions of concern. Visualization includes general body viewing in a standard position, front, back, and side. All symptomatic (painful) body parts may be viewed. At all times patient dignity and personal privacy will given the utmost respect. Women may request a female observer to be present at any time during examination and/or treatment.
- Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.
- Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
- Percussion: Manual or tool-assisted vibration/tapping on bones or tendons.
- Orthopedic/neurological testing: standard neuromusculoskeletal evaluation procedures.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Risks from treatment

<u>Soreness:</u> I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

<u>Dizziness:</u> Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform Dr. Meanley D.C. if you experience these symptoms.

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Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative discs, or other abnormalities are detected, the doctor will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke have been reported to occur somewhere between once in one million to once in ten million treatments. Once in a million is roughly the same chance as being hit by lightning. Once in ten million is about the same risk of a standard dose of aspirin or Tylenol causing death.

Physical Therapeutics: Some therapies that may be used in accordance with your care include methods that generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of my treatment.

I agree to the performance of these procedures by my doctor and his team/employees/assistants.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

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Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, orother home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability, muscle tears, serious disc herniations, and other conditions. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-Treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I have any questions and given satisfactory explanation where appropriate. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Printed Name of patient:

____

Signature/Guardian of patient:

____Date:__________________

I explained the procedures, alternatives, and risks in this Informed Consent in conference with the patient.

Doctor's Signature:

____Date:__________________

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NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Dr. Meanley D.C. is required , by law, to maintain the privacy and confidentiality of your protected health information and to provide his patients with notice of his legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. For example, it is our policy to provide a substitute healthcare provider, authorized by Dr. Meanley D.C., to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situation.

Worker's Compensation: We may disclose health information as necessary to comply with State Workers' Compensation Laws.

Emergencies: We may disclose health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of emergency or of your death.

Public Health: As required by law, we may disclose health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

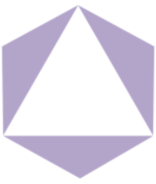
Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement: We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness, missing persin, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons: We may disclose your health information to coroners or medical examiners.

Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.



Specialized Government Agencies: We may disclose your health information for military, national security, prisoner and government benefit purposes.

Change of Ownership: In the event that *Rebalance Chiropractic* is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that *Rebalance Chiropractic* is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method when sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy health information.
- You have a right to request that *Rebalance Chiropractic* amend your protected health information. Please be advised, however, that *Rebalance Chiropractic* is not required to agree to amend your protected health information. If your request to amend is denied, you will be provided with an explanation of our denial reason.
- You have the right to receive an accounting of disclosures of your protected health information made by Dr. Meanley D.C.
- You have a right to a paper copy of this notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy

Dr. Meanley D.C. reserves the right to amend this Notice at any time in the future, and will make the new provisions effective for all information that it maintains. Dr. Meanley D.C. is required by law to maintain the privacy of your health information and to provide you with notice of legal duties and privacy practices with respect to such information. If you have questions about any of these issues, please contact our office.

Complaints

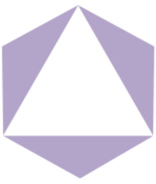
If you wish to make a complaint about your privacy you may make an appointment for personal conference with our office within 2 working days. If you are not satisfied with such complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Avenue, S.W.

Room 509F HHH Building

Washington, DC 20201



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I have read the Privacy Notice and understand my rights contained therein.

By way of signature, I provide Dr. Meanley D.C. and *Rebalance Chiropractic* with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice.

Patient's printed name:____

Patient's/Guardian signature:____Date:____________________

Authorized Facility Signature:

__________________________________Date:__________________