# New Patient Health History Form

**In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.**

## Patient Data

First Name ____ Last Name ____ Date ____ Email* ____

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

## Mailing address

Address ____ City ____ State ____ Zip ____

Telephone (Work) ____ (home) ____ Referred By ____

Age ____ Birth Date ____ Social Security # ____ Number of Children ____

Occupation ____ Employer ____

Marital Status ____ Spouse's Name ____ Spouse's Occupation ____

Spouse's Employer ____ Spouse's Health Status ____

Emergency Contact ____ Phone ____

## Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe: ____

Date of Injury ____ Date symptoms appeared ____

Have you ever had same condition? ○ No ○ Yes If yes, when? ____

List of other practitioners seen for this injury/condition ____

Have you ever been under chiropractic care? ○ No ○ Yes

If yes, please describe ____

## Insurance Information

Name of party responsible for payment ____ Phone ____

Do you have health insurance? ○ No ○ Yes Name of company ____

*** If an auto accident, please provide:**

Insurance Company Name ____ Contact Person ____

Phone: ____ Claim # ____

## Signatures

Name of the insured ____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature ____ Date ____

Spouse's or guardian's signature ____ Date ____

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## Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes | If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)!

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

| Have you ever: | No | Yes | Briefly Explain |
|---|---|---|---|
| Broken bones? | ○ | ○ | |
| Been hospitalized? | ○ | ○ | |
| Been in an auto accident? | ○ | ○ | |
| Had Sprains/Strains? | ○ | ○ | |
| Been struck unconscious? | ○ | ○ | |
| Had surgery? | ○ | ○ | |

## Family History

**Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

| | | |
|---|---|---|
| Do you experience pain every day? | ○ No | ○ Yes |
| Do your symptoms interfere with daily life? | ○ No | ○ Yes |
| Does pain wake you up at night? | ○ No | ○ Yes |
| Are your symptoms worse during certain times of the day? | ○ No | ○ Yes |
| Do changes in weather affect your symptoms? | ○ No | ○ Yes |
| Do you wear orthotics? | ○ No | ○ Yes |
| Do you take vitamin supplements? | ○ No | ○ Yes |

What activities aggravate your symptoms?

| Habits | None | Light | Moderate | Heavy |
|---|---|---|---|---|
| Alcohol | ○ | ○ | ○ | ○ |
| Coffee | ○ | ○ | ○ | ○ |
| Tobacco | ○ | ○ | ○ | ○ |
| Drugs | ○ | ○ | ○ | ○ |
| Exercise | ○ | ○ | ○ | ○ |
| Sleep | ○ | ○ | ○ | ○ |
| Appetite | ○ | ○ | ○ | ○ |
| Soft Drinks | ○ | ○ | ○ | ○ |
| Water | ○ | ○ | ○ | ○ |
| Salty Foods | ○ | ○ | ○ | ○ |
| Sugary Foods | ○ | ○ | ○ | ○ |
| Artificial Sweeteners | ○ | ○ | ○ | ○ |

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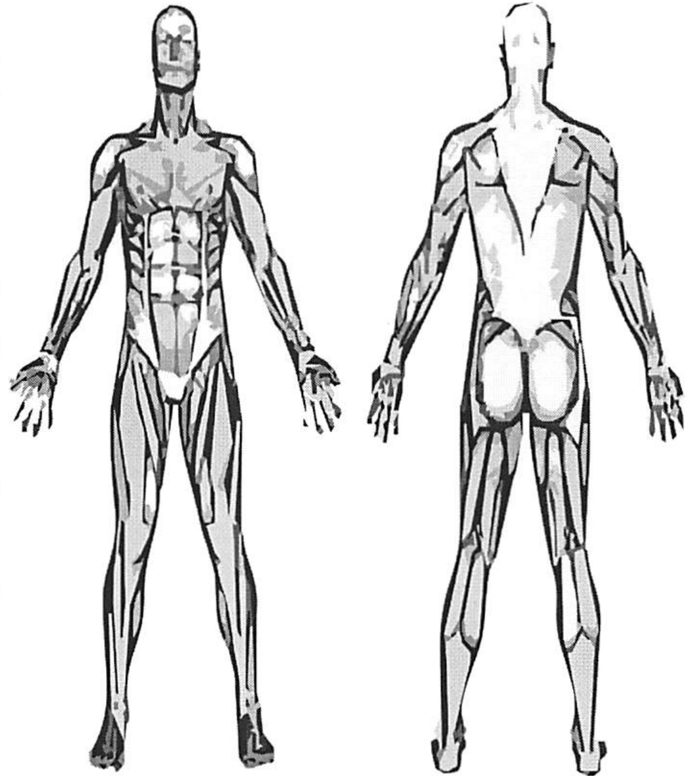
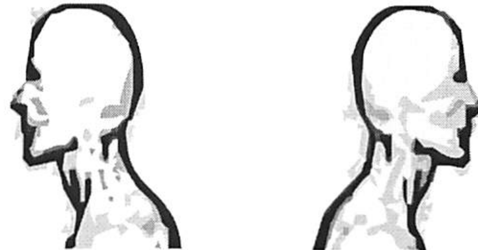
**Have you ever suffered from:**

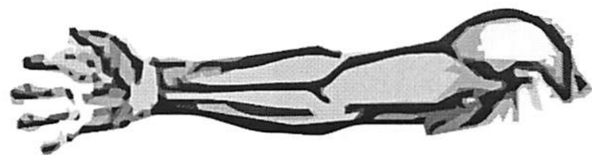
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: ________

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

| | |
|---|---|
| **A**=Ache | **O**=Other |
| **B**=Burning | **P**=Pins & Needles |
| **N**=Numbness | **S**=Stabbing |







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# FOCUS CHIROPRACTIC CENTER

1123 Celis Street
San Fernando, Ca 91340
(818) 838-4900 Fax: (818) 838-4901

**PATIENT'S NAME:** ______________________ **TODAY'S DATE:** ____________

## YOUR MEDICAL HISTORY

Do you suffer from?

| | | | |
|---|---|---|---|
| High Blood Pressure | _____ | Diabetes | _____ |
| Arthritis | _____ | Tuberculosis | _____ |
| Ulcers | _____ | Kidney/Liver Disease | _____ |
| Epilepsy | _____ | Heart Disease | _____ |
| Others | ______________________ | | |

Previous Surgeries or Hospitalizations: ______________________

ALLERGIES (Please include all to drugs/food/etc.) ______________________

PREVIOUS WORK OR/AND CAR ACCIDENTS: Please, give dates, injuries, treatment & residuals, if any)

______________________

## YOUR HABITS

Do You: Drink Coffee _____ Drink Alcohol _____ Use Tobacco _____ Use Illicit Drugs _____

How much of each? _____ _____ _____ _____

Do You: Use any prescribed medication? ____
Names: ______________________

Did/Do You: Take any medication **after** this accident? ___ Names: ______________________

Do you Exercise Regularly? Yes / No How Often? ______________________

Have you stopped your exercise habits since the accident? ______________________

## FAMILY HEALTH PROBLEMS (please, only major medical illnesses such as diabetes, cancer, HBP, etc.)

Mother's Health History: ______________________

Father's Health History: ______________________

Other Blood Relative: ______________________

**YOU ARE:** **MARRIED** **SINGLE** **YOU HAVE:** **CHILD(REN)**

# *Focus Chiropractic Center*

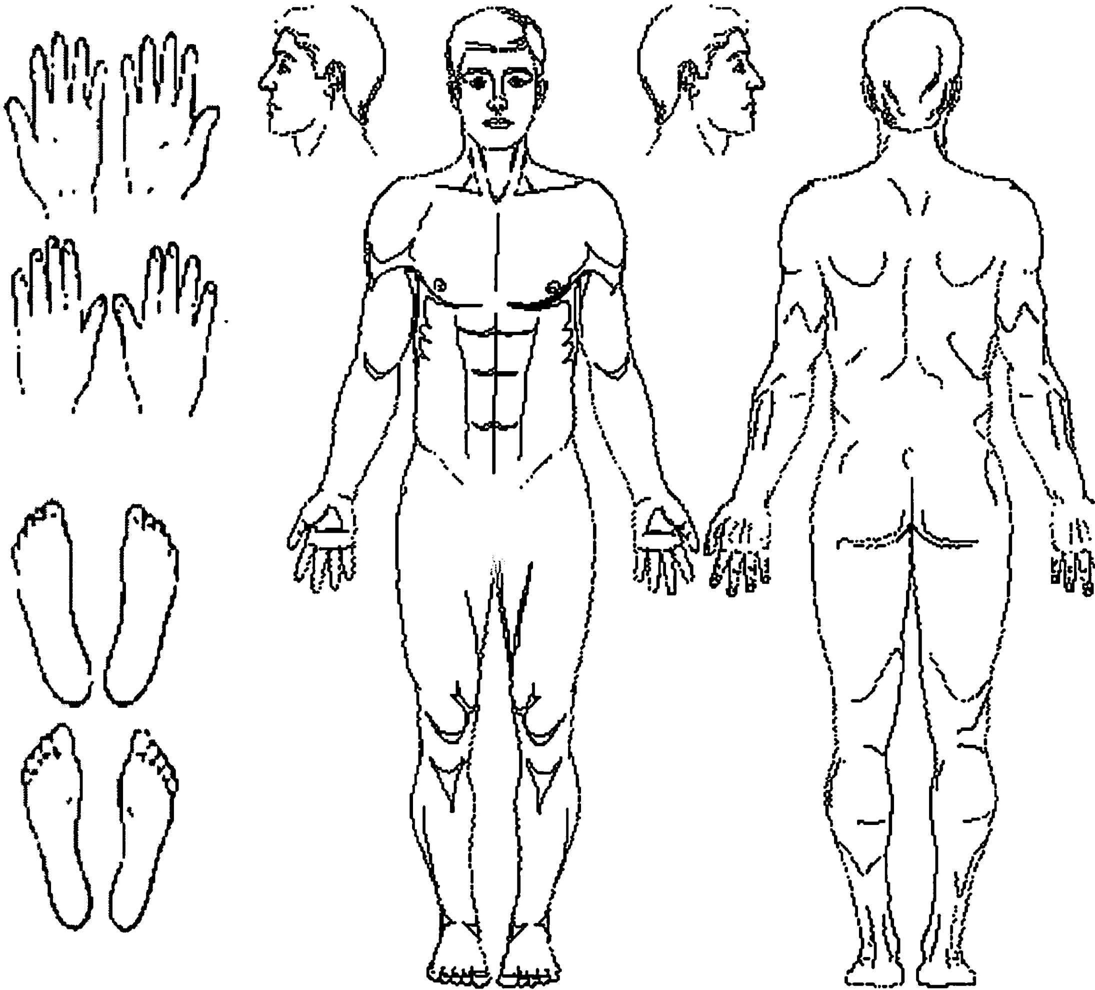
1123 Celis Street - San Fernando, CA. 91340
Phone (818) 838-4900 - Fax (818) 838-4901

## SUBJECTIVE COMPLAINTS

Date: ____________________

PATIENT'S NAME ________________________________________ AGE _____

**PLEASE, MARK YOUR AREAS OF PAIN AND RATE EACH AREA:**
**Scale from 1 to 10 (1 for very mild pain to 10 for unbearable pain).**



# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays, and physical therapy techniques, on me (or on the patient named below, for whom I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or on the future, render treatment to me, while employed by, working for, or associated with or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interests.

I have an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

**LIDIA ALZATE, D.C.**
**1123 Celis Street, San Fernando, CA. 91340**
**Phone: (818) 838-4900 Fax (818) 838-4901**
**Phone: (818) 842-7700 Fax (818) 842-7001**

Print Name(s) of Doctor Treating This Patient

______________________________

______________________________

______________________________

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

______________________________ ______________
Printed Name of Patient Date

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Signature of Patient's Representative Date

______________________________ ______________
Witness to Patient's Signature Date

______________________________ ______________
Translated by Date

# Focus Chiropractic Center

## Dr. Lidia Alzate, D.C.

# CALIFORNIA
# LANGUAGE ASSISTANCE
# INFORMATION (CA LAP)

**DO YOU REQUIRE LANGUAGE ASSISTANCE? ( ) YES or ( ) NO**

**IF YES, WHICH LANGUAGE** ______________________________

You may be entitled to the rights and services below. These rights apply only under California law. However, these rights do not apply to all California residents. These rights do not apply to all languages.

Effective January 1, 2009, California health plans are required to implement a language assistance program to comply with Senate Bill 853. The legislation was passed to assist those with limited English language proficiency to better communicate and participate in personal health care matters.

The Department of Patient Safety is available to respond to questions related to the S.B.853 language service requirements. Please call (800) 421-2368, extension 1243, for assistance and support.

______________________________ ______________
Printed Name of Patient Date

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Signature of Patient's Representative Date

______________________________ ______________
Witness to Patient's Signature Date

______________________________ ______________
Translated by Date

**REQUESTER: Dr. LIDIA ALZATE, D.C.**
1123 Celis Street – San Fernando, California 91340
Phone # (818) 818-838-4900 - Fax # (818) 838-4901
***Medical Records can be emailed to: Dralzate@focuschiropracticcenter.com**

## AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

FACILITY PROVIDING RECORDS

______________________________
______________________________
______________________________
______________________________

**Date of Request:** ____________________

I hereby authorize ______________________________ to release and/or disclose the medical information as indicated below to the health care provider named above.

Patient's Full Name: ______________________________

Patient's Address: ______________________________

Patient's Date of Birth: ____/____/____ Patient's SS# ________________

Patient's Signature: ______________________ Date:__________
Indicate relationship if signed by other than patient.

DURATION: This authorization shall become effective immediately and shall remain in effect until __________ (enter date) or for one year from the date of signature if no date entered.
REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.
REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

### SPECIFIC RECORDS TO BE RELEASED AND/OR DISCLOSED (circle one):

1) General Medical Information from ____________________ to ____________________.

2) Information pertaining specific injury or treatment from ______________ to ____________.

3) X-rays: films and/or reports (circle one or both)

4) Other: Specify__________________________ __________________________.

Patient's Signature:______________________________

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purpose only: management of injuries sustained on ____________________.
A copy of this Authorization is valid as an original. I have the right to receive a copy of this authorization.

# FOCUS CHIROPRACTIC CENTER – DR. LIDIA ALZATE, D.C.
# NOTICE OF PRIVACY PRACTICES

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.

**Focus Chiropractic Center (Dr. Lidia Alzate, D.C.)** is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our 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. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Focus Chiropractic Center (Dr. Lidia Alzate, D.C.)."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Focus Chiropractic Center (Dr. Lidia Alzate, D.C.)to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

### Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

*"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

### Workers' Compensation

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

### Emergencies

We may disclose your 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 an emergency or of your death.

### Public Health

As required by law, we may disclose your 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 proceeding.

### Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, 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.

### Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

### 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 benefits purposes.

**Marketing.**

We may contact you for marketing purposes or fundraising purposes, as described below: (example) *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Focus Chiropractic Center (Dr. Lidia Alzate, D.C.)sponsored fund-raising events."*

**Change of Ownership.**

In the event that Focus Chiropractic Center (Dr. Lidia Alzate, D.C).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 Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) 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 or 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 your health information.
- You have a right to request that Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) amend your protected health information. Please be advised, however, that Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Focus Chiropractic Center (Dr. Lidia Alzate, 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 Practices**

Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) is required by law to comply with this Notice.
Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Lidia Alzate, chiropractor by calling this office at (818) 842-7700. If Dr. Alzate is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints**

Complaints about your Privacy rights, or how Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) has handled your health information should be directed to Dr. Lidia Alzate, D.C. by calling this office at (818) 842-7700 If Dr. Lidia Alzate, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your 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

This notice is effective as of ______/______/_______

I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature, I provide Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

______________________________________
Patient's Name (print)

______________________________________ ____________
Patient's Signature Date

______________________________________ ____________
Authorized Facility Signature Date

WELCOME TO *Focus Chiropractic Center- Dr. Lidia Alzate, D.C.*

If you would like to receive Newsletters and updates, please provide us with your e-mail address.

YOUR E-MAIL ADDRESS HERE:______________________________________________

**You can look us up at www.focuschiropracticcenter.com, YELP and Facebook.**

We would like to share with you some of our company policies which we believe will improve the quality of our services:

1. If you have any questions or concerns regarding your treatment course, required documentation and/or medical recommendations, please, feel free to contact our the doctor or our office staff.
2. Make sure you follow the doctor's prescription for treatment and management of your condition. Following the doctor's recommendations is the most important step towards benefiting from the treatment prescribed.
3. If you were recommended x-rays and/or any other diagnostic studies, our office staff will assist you with the appointments and/or referrals. Make sure you follow the instructions for the studies and have them done as soon as possible. If you are unable to have the studies performed or choose not to have them done, please, notify our office immediately.
4. If you were recommended specialized consultations, we will try to assist you with the appointments for these consultations as well. Please, be aware that if you are referred to another facility or another physician for consultation and/or care, you will need to provide that facility and/or that other physician with all your information. Even though you might have authorized us to disclose your records to them, that other facility will request information directly from you. All the documentation signed to our office and/or to a specific physician does not apply to all other physicians or facilities you might be referred to.
5. We do not allow pets in our offices.
6. No food or drink allowed in any area of our facility, including the waiting area and treatment area.
7. Turn off your cell phone in any area of our office. For your and other patients' comfort and relaxation, we do not allow the use of cellular phones in the offices. If you have urgent matters to address via cell phone, please step outside.
8. We do not allow children unattended in our offices. We do not provide child care service. Children must remain in the front area assisted by a responsible adult at all times. If the child is in the office to see the doctor and/or to undergo treatment, she/he must be accompanied by a parent/guardian at all times and in all areas of the office. We do not allow children unaccompanied in the restrooms.
9. Please, avoid arriving late to your appointment. We do take appointments for our treatment sessions in order to avoid prolonged waiting. By arriving late, you will be compromising your and other patients' treatment courses. We do accept and welcome walk-ins, but, please, understand that there might be a wait for the walk-in patients.
10. If you are unable to come in for your treatment visit, please, advise us in advance. We like to plan our and the doctor's schedules. The no-show will disturb our regular day schedule and will compromise your treatment course.
11. Come in for treatment as comfortable as possible. Avoid use of alcohol, drugs or tobacco immediately before your treatment or office visit. Avoid use of strong perfumes and/or lotions. We may use heat as part of your treatment. Please, do not bring valuables or large bags into the treatment rooms.
12. We are not responsible for personal lost items.
13. We do try to keep a relaxing atmosphere in our offices. Therefore, we try to keep the noise volume down. If you must maintain loud conversations with others, please, do it outside the office.
14. We strive to avoid prolonged waiting. We do know when you come in and will be with you within minutes.
15. We do follow the doctor's prescription for your treatment. This might include physiotherapy. The physiotherapy will include several modalities and procedures. If you are not familiar with a modality or procedure, do not feel comfortable or notice increasing pain or discomfort while undergoing any of them, please, let us know immediately.

We hope that we can help and assist you. We feel honored you have chosen our office for your care.

I received copy of the Welcome letter. ______________________________________

Patient's Signature & Date