DESMARAIS CHIROPRACTIC, INC.

Ronald Desmarais—Chiropractor
1405 Huntington Avenue•Suite 102•South San Francisco•California•94080

CONFIDENTIAL PATIENT INFORMATION

Name_______________________________________ Age_______ D.O.B.____________________

Address____________________________________ City________________________ Zip__________

Driver's License #:____________________SSN____________________ Marital Status: M S W D

Home Phone Number: (_____)____________________ Cell Phone Number: (_____)____________________

Occupation____________________________ Employer____________________________________

Employer Address__________________________________ Office Phone(_____)________________

Name of Spouse or Nearest Relative____________________ Contact Number (_____)________________

Female: Are you pregnant? ☐ Yes ☐ No How long? ________ wks/months

So that we may provide you the information you will need regarding our office and your condition, please provide us with your e-mail address here: E-mail____________________________________

Whom may we thank for referring you to our office?____________________________________

Why Chiropractic? People seek Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort **(Relief Care)**, others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved **(Corrective Care)**, and others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care **(Comprehensive care)**. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check type of care desired so that we may be guided by your wishes whenever possible:

- ☐ Relief Care
- ☐ Corrective Care
- ☐ Comprehensive Care
- ☐ Check here if you want the Doctor to select the type of care appropriate for your condition

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

Are you insured? ☐ Yes (Please give a copy of your insurance card to the front desk) ☐ No

Company:____

If information below is different than above, please answer the following questions

Policy Holder:____

Relationship: ☐ Spouse ☐ Parent ☐ Other:____________________________

Social Security #:____________________ Date of Birth:____________________

______________________________ ______________________________

Patient's Signature ***Date***

CHIROPRACTIC HEALTH QUESTIONNAIRE

Reason for visit:______________________________

Is this condition the result of : ☐ Motor Vehicle Collision ☐ Work Injury ☐ Other:______________

↳If yes, date:__________ time:________ a.m. / p.m.

Have you lost any days of work? ☐ Yes → Date(s):____________ ☐ No

Have you had similar accidents or injuries before? ☐ Yes ☐ No

Have you been treated before for this problem? ☐ Yes ☐ No

↳If yes, by ☐ Physician ☐ Chiropractor ☐ Physical Therapist ☐ Osteopath ☐ Other______________

What did they do and/or recommend?______________________________

When did your symptoms appear?____________________

Is this condition getting progressively worse? ☐ Yes ☐ No

Describe your symptoms:

☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant → ☐ Prevents Sleep ☐ All waking hours 16/24

☐ Dull ☐ Achy ☐ Sharp/Stabbing ☐ Tingling ☐ Numbness ☐ Deep ☐ Superficial

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform:

☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Other:______________________

Describe activities at work (lifting, standing, sitting, etc. and how much time you spend doing them):

____

Have you ever had chiropractic care for other problems? ☐ Yes → When?____________________ ☐ No

Have you been treated for any health conditions by a physician in the last year? ☐ Yes ☐ No

↳If yes, describe:______________________________

Do you take: ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin

☐ **Birth Control Pills** ☐ Over-the-Counter Meds

☐ Other Prescription Drugs (Please list all medications on back page)

List all surgeries:

☐ None

☐ Date/Surgery:______________________________

Date of last: Physical Exam ____________

Spinal Exam ____________

Spinal X-ray ____________

Chest X-ray ____________

Dental X-ray ____________

MRI, CT-scan, bone scan ____________

Blood Test ____________

Urine Test ____________

Sleep: ______hours/night on your ☐ back ☐ side ☐ stomach

Age of mattress: ______ waterbed: ________

Is your bed comfortable? ☐ Yes ☐ No

What kind of pillow do you use? ☐ Thick ☐ Medium ☐ Thin ☐ None ☐ Support

Non-job exercise: _______ hours/week

Do you wear: ☐ Heel Lifts ☐ Shoe Lifts ☐ Arch Supports ☐ Orthotics, describe:______________

History of Smoking ☐ No ☐ **Yes** → _________yrs ☐ Cigarettes ☐ Cigars ☐ Quit → ________yrs

How would you rate your current level of fitness: ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

CHIROPRACTIC HEALTH QUESTIONNAIRE

CONDITIONS CHECK ANY CONDITIONS YOU HAVE CURRENTLY OR HAVE HAD IN THE PAST

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Chronic Fatigue Syndrome
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibrocystic Breast Disease
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gingivitis
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Guillaine Barre
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Myasthenia Gravis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Rubella
- ☐ Rubeola
- ☐ Sarcoidosis
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Trigeminal Neuralgia
- ☐ Tuberculosis
- ☐ Tumors, growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other________________

____

____

____

____

____

NECK, BACK, EXTREMITIES CHECK ANY SYMPTOMS YOU HAVE CURRENTLY OR HAVE HAD IN THE PAST YEAR.

NECK

- ☐ **Neck Pain**
- ☐ Neck Stiffness
- ☐ Neck Weakness
- ☐ Neck Tingling/Numbness
- ☐ Neck Feels Out of Place
- ☐ Muscle Spasms in Neck
- ☐ Grinding/Popping Sounds in Neck

SHOULDERS

- ☐ Pain in Shoulder Joint ☐ R ☐ L
- ☐ Pain Across Shoulders
- ☐ Can't Raise Arm ☐ R ☐ L
  - ☐ Above Shoulder Level
  - ☐ Overhead
- ☐ Tension in Shoulders
- ☐ Shoulder Tingling/Numbness ☐ R ☐ L

MID-BACK

- ☐ Mid-Back Pain
- ☐ Mid-Back Stiffness
- ☐ Pain Between Shoulder Blades
- ☐ Pain From Front to Back
- ☐ Muscle Spasms in Mid-Back

ARMS & HANDS

- ☐ Pain in Upper Arm ☐ R ☐ L
- ☐ Pain in Elbow ☐ R ☐ L
- ☐ Pain in Forearm ☐ R ☐ L
- ☐ Pain in Hand ☐ R ☐ L
- ☐ Pain in Fingers ☐ R ☐ L
- ☐ Pins & Needles in Arm ☐ R ☐ L
- ☐ Pins & Needles in Fingers ☐ R ☐ L
- ☐ Numbness in Arm ☐ R ☐ L
- ☐ Numbness in Fingers ☐ R ☐ L
- ☐ Weakness of Arm ☐ R ☐ L
- ☐ Weakness of Hand ☐ R ☐ L
- ☐ Hands Cold ☐ R ☐ L

LOW BACK

- ☐ Low Back Pain
- ☐ Low Back Stiffness
- ☐ Low Back Weakness
- ☐ Low Back Tingling/Numbness
- ☐ Low Back Feels Out of Place
- ☐ Low Back Muscle Spasms

HIPS, LEGS & FEET

- ☐ Pain in Buttocks ☐ R ☐ L
- ☐ Pain in Hip Joint ☐ R ☐ L
- ☐ Pain Down Leg ☐ R ☐ L
- ☐ Pain in Knee ☐ R ☐ L
- ☐ Pain in Ankle ☐ R ☐ L
- ☐ Pain in Foot ☐ R ☐ L
- ☐ Weakness of Leg ☐ R ☐ L
- ☐ Weakness of Knee ☐ R ☐ L
- ☐ Leg Cramps ☐ R ☐ L

OTHER SYMPTOMS:

____

____

Chiropractic Health Questionnaire

General Symptoms Check any symptoms you have currently or have had in the past <u>year</u>

General
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ **Dizziness**
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ **Numbness**
- ☐ **Severe Headache**
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight Gain

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Genito-Urinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Loss of Bladder Control
- ☐ Painful Urination
- ☐ Loss of Bowel Control

Gastrointestinal
- ☐ Decreased Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ **Nausea**
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Eye, Ear, Nose & Throat
- ☐ Bleeding Gums
- ☐ **Blurred Vision**
- ☐ **Crossed Eyes**
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ **Hoarseness**
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Teeth Grinding
- ☐ Vision—Flashes
- ☐ Vision—Halos

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Men Only
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

Women Only
- ☐ Abnormal PAP Smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other

Date of last menstrual period:________________

Date of last PAP smear:

____

Have you had a mammogram?

____

Are you pregnant?________

Number of children________

Medications List all medications you are currently taking

____

________________________________ ________Allergies:________________________

Pharmacy Name:________________________________ Ph:(_____)________________

Vitamins / Herbs / Minerals

____

____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

________________________________ ________________

Patient Signature Date

Reviewed by:________________________ ________________

Date

INFORMED CONSENT

Patient Name: ________________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experience when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

______Spinal manipulative therapy
______Radiographic studies
______Palpation
______Neurological testing
______Muscle stimulation
______Range of motion testing
______Inversion therapy
______Orthopedic testing
______Cold therapy
______Muscle strength testing
______Cold laser therapy
______Postural analysis
______Vital signs

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of you history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.**

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Ronald and/or Dr. Charisse Desmarais and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

______________________________ Print Patient's Name

______________________________ Signature of Patient

Date Signed ______________________

☐ Dr. Ronald R. Desmarais
☐ Dr. Charisse M. Desmarais

______________________________ Doctor's Signature

______________________________ Print Parent or Guardian's Name (if a minor)

______________________________ Signature of Parent or Guardian

Desmarais Chiropractic Inc.
Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At **Desmarais Chiropractic Inc.**, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your case.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a collection agency. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use disclose your health information without your prior written authorization
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have a right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy if your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the **Department of Health and Human Services,** 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at **(650) 588-9962**
- This notice goes it effect as of April 14,2003

ACKNOWLEDGEMENT

I have received a copy of the **Desmarais Chiropractic Inc Notice of Privacy Practices**.

Signed: ______________________ Print Name:______________________ Date: __________

Desmarais Chiropractic
1405 Huntington Ave. Ste. #102
South San Francisco, CA 94080

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_________________________ **Last Name:**_________________________

Email address: _________________@________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** __________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): __________________

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (___________)	Offspring: (___________)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date: ________________

PLEASE FILL THIS BOX OUT WE WILL TAKE YOUR BLOOD PRESSURE AND HEART RATE
Height: _________ Weight:____________ Blood Pressure:______/______ HR: _____