SALDAÑAS CHIROPRACTIC & WELLNESS CENTER

CONFIDENTIAL PATIENT INTRODUCTION

Date:
Fecha: _______

Patients Name — Phone No:
Nombre del paciente ____________________ Número de Teléfono _______

Home Address — City — Zip Code
Dirección de Casa____________________ Ciudad________ Código Postal_____

Age — Date of Birth — Soc. Sec. No
Edad____ Fecha de nacimiento__________ Número de Seguro Social __________

Occupation — Drivers License No
Occupación ____________________ Número de Licencia de manejar ______

Employer's Name — Phone Number
Nombre de Trabajo________________ Número de Teléfono de Trabajo_______

Employer's Address — City . — Zip Code
Dirección de Trabajo________________ Ciudad_________ Código Postal______

Name of Wife or Husband — Phone No
Nombre de Esposo(a)________________ Teléfono de Esposo(a)____________

Wife or Husband Employer Name — Phone No.
Nombre de Esposo(a) Trabajo________________ Teléfono de Trabajo________

Patient's Nearest Relatives-(Not living with you)
Nombre de Pariente (que no viva con ud.)____________________________

Address — Phone Number
Dirección________________ Número de Teléfono___________

Have you had previous chiropractic care? — When?
A tenido tratamiento quiropráctico antes? ____________________Cuándo?______

Who referred you to this office?
Persona que lo refirio a nuestra oficina ____________________________

ARE YOU COVERED BY INSURANCE? TIENE UD. ASEGURANZA?

___Blue Cross/Blue Shield
___Group Health mil Accident Insurance
___Union Health Benefit Plan
___Accident & Health (individual)
___Medical & Surgical Service Plan
___Medicare/Medicaid
___Interscholastic Insurance
___Other (cash)
___PPO/HMO
___Disability Insurance
___Owner's Landlord & Tenants
___State Workers Compensation
___Federal Workers Compensation
___Federal Employee Health Benefits
___Auto Accident Insurance

PAYMENT IS EXPECTED AT THE TIME OF VISIT (unless specific arrangement are made with the doctor)
EL PAGO DEBE HACERSE EL DIA DE LA CONSULTA (al menos que arreglos especiales sean hechos con el doctor)

Name of person responsible for payment
Nombre de la persona responsable por el pago______________________________

PLEASE NOTE: This office will gladly prepare insurance forms and repots; however we cannot render service on the assumption our charges will be paid by the insurance company. All professional services are charged directly to the patient, therefore, basic responsibility is yours.

POR FAVOR NOTE: ESTA OFICINA PREPARARA LAS FORMAS DE SEGURO CON MUCHO GUSTO, SIN EMBARGO, NO PODEMOS ASUMIR QUE LOS COSTOS SERAN PAGADOS POR SU ASEGURANZA, POR LO TANTO LA RESPONSABILIDAD DE PAGO ES FUNDAMENTALMENTE SUYA

Signature — Date
Firma ________________________________ Fecha _________

Patient Intake Form

¿Dé una descripción breve del problema que está experimentando actualmente: ______________________________

____

____

¿Cuánto tiempo tiene con esta condición? __________ Está empeorando? □ Si □ No ______________

Lo molesta (elija la caja que aplique): □ Trabajo, □ Mientras duerme, □ Otro: ______________

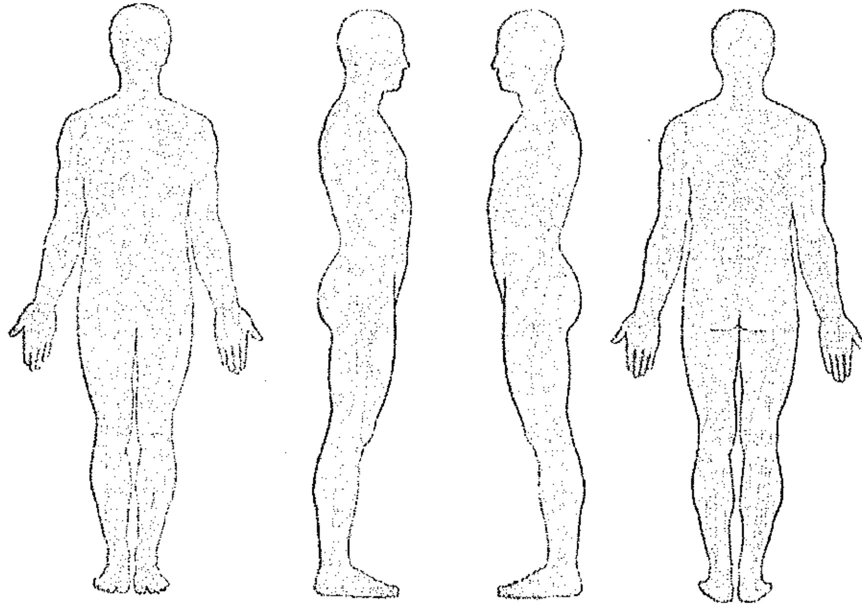
¿Qué pareció ser la causa inicial?: ______________________________

Por favor indique el área(s) de dolor en las figuras

Coloque por favor una marca en el nivel de su dolor en la escala:

Peor Dolor Posible

Sin Dolor



Alguna vez ha padesido de:

__Alergias	__Desmayos	__Estrenimiento	__Quistes en los Cenos
__Dolor de cuello	__Dolor de Cintura	__ Mareos	__Enfermedades venerias
__Mala postura	__huesos fracturas	__Fatiga	__Esguinces/desgarres
__Nervio ciatico	__Cancer	__Hemorragia Nasal	__Hinchazon de tobillos
__Sinusitis	__Perdida de peso	__Varices	__Mala circulacion
__Derrame cerebral	__Sordera	__Asma	__Anemia
__Perdida de balance	__Alcoholismo	__Diabetes	__Tuberculosis
__Mal orina	__Hemorroides	__Mala Digestion	__Nerviosismo/Depresion
__Respiracion Dificil	__Artritis	__Tiroides	__Palpitacion acelerada
__Mareos	__Alta presion	__Baja Presion	__Dolores de cabeza
__Dolor del Corazon	__Polio	__Hepastitis	__Entumecimiento
__Piedras en los rinones	__Orina muy seguido	__Colitis	__Flujo menstrual excesivo

Hábitos	nada	poco	mod.	mucho
Alcohol	□	□	□	□
Café	□	□	□	□
Tobaco	□	□	□	□
Drogas	□	□	□	□
Ejercicio	□	□	□	□
Sal	□	□	□	□
Azucar	□	□	□	□
Sueño	□	□	□	□
Agua	□	□	□	□
Refrescos	□	□	□	□

Si algún familiar de sangre ha tenido cualquiera de las condiciones siguientes, por favor indica la condición y la relación.

□ Alcoholismo	□ Cáncer	□ Presión alta
□ Anemia	□ Diabetes	□ Colesterol alto
□ Arteriosclerosis	□ Enfisema	□ Esclerosis múltiple
□ Artritis	□ Epilepsia	□ Osteoporosis
□ Asma	□ Glaucoma	□ Derrame cerebral
□ Sangra fácilmente	□ Enfermedad cardiaca	□ Enfermedad de tiroides

Usted tiene cualquier otro problema de salud o preocupaciones que nuestro personal debe saber? ______________

____

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Patient Intake Form (side 2)

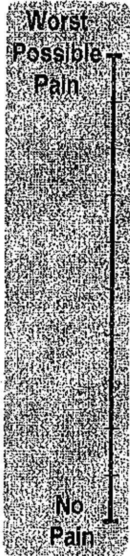
Give a breif detailed description of the problem you are currently experiencing: ____________________

How long have you had this condition? __________ Is it getting worse? ☐ yes, ☐ no __________

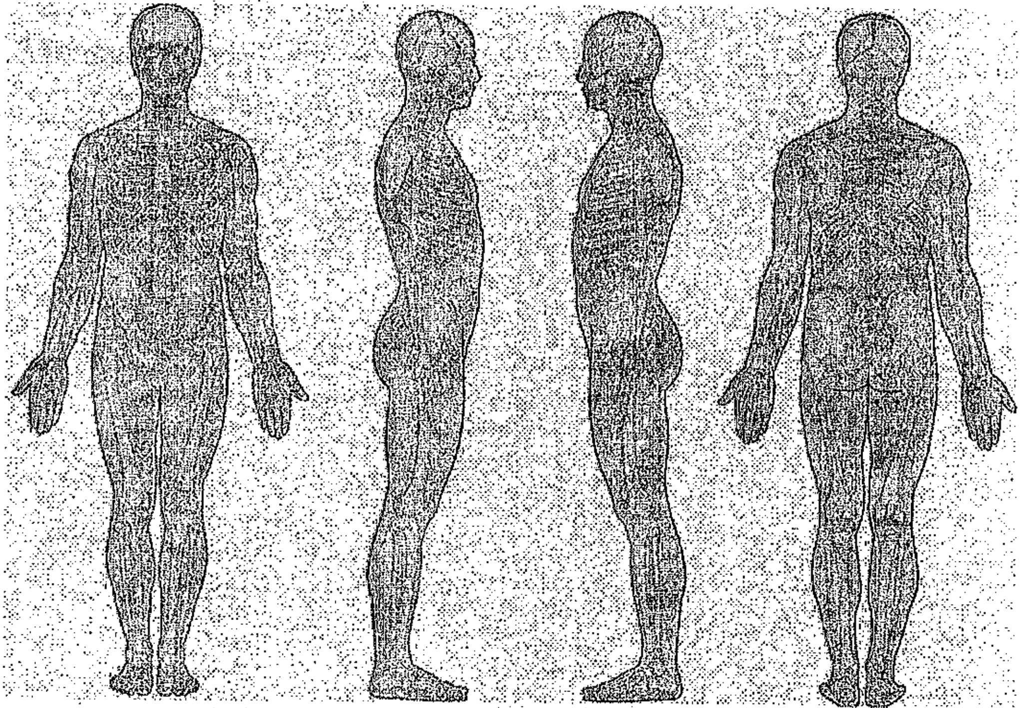
Does it bother you (check appropriate box): ☐ work, ☐ sleep, ☐ other: __________

What seemed to be the initial cause: __________

Please place a mark at the level of your pain on the scale below:



Please mark you area(s) of pain on the figure below



Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	☐	☐	
... had any mental disorders?	☐	☐	
... had any broken bones?	☐	☐	
... had any strains or sprains?	☐	☐	
... ever used orthotics?	☐	☐	
Do you take minerals, herbs or vitamins?	☐	☐	

How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: __________

How old is your matress? __________

When was your last physical exam? __________

Habits	none	light	mod.	heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleed easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? __________

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Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: ______________________ **Date:** ________ (dd/mm/yr)

Insurance: ______________________

Date of Birth: ______________________ ☐ male ☐ female

Address: ______________________

____

____

Marital status

S	M	W	D	SEP

Phone #: home: ____________ **work:** ____________

E-mail address: ______________________

Occupation: ____________ **Employer:** ____________

Mark (c) for current problems, check E and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Lenght of cycle: ______

Date - 1st day last period: ____________

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? ____

How many children do you have? ____

Birth control method: ____________

Date of last PAP test: ____________

☐ normal, ☐ abnormal

Date of last mamogram: ____________

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why

____

____

____

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SALDANA'S CHIROPRACTIC & WELLNESS CENTER

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSURE AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Saldaña's Chiropractic Center we may use or Disclose personal and health related information about you in the following ways:

- Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information may be of interest to you.
- Your name in our office bulleting or other boards for purpose of announcing birthdays or acknowledging your referrals.
- The practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we require by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in your professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you

SALDANA'S CHIROPRACTIC & WELLNESS CENTER

regarding your health care or about the status of your home or, if you would like the information is a different form please advice us in writing as to your preference.
You have the right to inspect and/or copy your health information for seven years form the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Request to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health information therein. We are also required to provide you with this notice of your privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practice or any aspect of our privacy activities you should direct your complaint to:
Luis A Saldaña D.C.

This notice is effective as of ____________. This notice, and any alteration or amendment made hereto will expire seven years after the date upon which record was created. My signature acknowledges that I have received a copy of this notice.

______________________________ ______________________________ __________

Name (Printed please) Signature Date

If your are a minor, or you are being represented by another party

______________________________ ______________________________ __________

Personal Representative Printed Personal Representative Signature Date

____

Description of the authority to act on behalf of the patient

SALDAÑA'S CHIROPRACTIC & WELLNESS CENTER

CONDITIONS FOR CARE

YOUR UNDERSTANDING AND AUTHORIZATION IN NEEDED BEFORE CARE CAN BE PROVIDED: The is a consent to treat form authorizing Dr. Saldaña to examine and prescribed any appropriate treatment, with your understanding of possible risks which may be present with any medical procedures. A permission is also asked in case your insurance company, attorney, family doctor, or employer requests documentation of your treatment. A reminder that all services rendered by Dr. Saldaña will be ultimately your responsibility. And lastly, a declaration, that your injuries are of a legitimate nature and any illegal practices, will be subjected to all applicable penalties of perjury.

1) CHIROPRACTIC AND MEDICAL CONSENT: The undersigned patient consents to any necessary x-rays examination, laboratory, therapeutic procedure, chiropractic, nutritional/herbal, and medical treatment rendered to the patient under the general and special instructions of Dr. Saldaña or qualified staff or affiliated specialist. It is the patient's privilege to refuse any recommended chiropractic of medical procedure in which case the patient will release the chiropractor, staff, and clinic from any responsibility as to the possible outcome of the patient's condition.

I understand and am informed that, as in the practice of medicine, there are some risks to chiropractic treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect Dr. Saldaña to anticipate and explain all the risks and complications, and will trust Dr. Saldaña to exercise his optimal professional judgment during the course of my necessary care at which time, based upon the facts then known, is in my best interest.

Any concerns and questions of additional elaboration are of your responsibility and strongly encourage to be asked to the doctor before continuing care. The doctor will intermittently pause during such examinations and treatment to address any questions and concerns, which you may have. I also understand the nature and purpose of chiropractic adjustments and other procedures and understand that results are not the same for all procedures and services are therefore not guaranteed.

I have read, or had read to me, the above consent and by signing below I consent to treatment for my present condition and for any future condition(s) for which I seek treatment.

2) RELEASE OF INFORMATION: The office of Dr. Luis Saldaña may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the clinic for all or part of Dr. Saldaña's charges. Including but not limited to, medical service companies, insurance companies, worker's compensation carrier, welfare funds or the patient's employer.

3) FINANCIAL AGREEMENT: The undersigned agrees, whether he/she as agent or as patient, that in consideration of service to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Dr. Saldaña in accordance with the regular rates and terms of Dr. Saldaña. Should the account be referred to an attorney for collections, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bare interest at the legal rate. There is also a twenty ($20) fee charged per returned check, as well as any fees charged by the bank.

4) DECLARATION UNDER PENALTY OF PERJURY: The undersigned hereby declares under penalty or perjury that he/she sustained personal injury on the injury date indicated and that all information communicated to Dr. Saldaña or staff pertaining to said injury is true and subject to penalty of perjury.

THE UNDERSIGNED CERTIFIES THAT HE/SHE READ THE FOREGOING AND IS THE PATIENT, OR IS DULY AUTHORIZED BY PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

PRINT PATIENT'S NAME　　PATIENT'S SIGNATURE　　DATE

GUARDIAN'S NAME & SIGNATURE　　DATE