Holistic Chiropractic Center

Today's Date: _____

230 Grand Ave. Suite 202 Oakland CA 94610
www.higherqualityoflife.com
(510) 606-6215

PLEASE TELL US ABOUT YOURSLEF

Basic Information

Name: _____ Sex: __ M __F __Other
First Middle Last
Address: _____
Street City State Zip Code
Home/Cell Phone: _____ E-Mail: _____
Date of Birth: ___/___/___ Age: _____ Weight: _____ Height: _____
Relationship: ◻ Single ◻ Boyfriend/Girlfriend ◻ Married ◻ Domestic Partner ◻ Divorced ◻ Widowed
Children('s):_____ Age(s): _____
Emergency contact:_____ Phone _____ Relation_____
Who referred you to our office? _____
Physician's Name: _____ Phone _____ Last Physical: _____
Please list (+) lab results: _____
Other Practitioners you are seeing right now : _____

Occupation

Occupation: _____ Employer: _____

Do you enjoy what you do? ◻ Yes ◻ No

Habits: ◻ Sit more than 6 hours/day ◻ Stand more than 6 hours/day ◻ Carry heavy objects

◻ Repetitively bend or twist ◻ Cradle the phone shoulder to ear (which side? L or R)

Desk job: ◻ Repetitively type ◻ Drive on the job (car or other) ◻ Lift more than 10lbs repetitively

Desk jot: Is your desk ergonomics set up? ◻ Yes ◻ No

Do you have a stand up desk? ◻ Yes ◻ No

Are you currently on a work release? ◻ Yes ◻ No Ordered by whom and why? _____

What brings you here?

__ General wellness __ Preventive care __Temporary relief __ Referred by another practitioner

What is/are your health concern? _____

What happened? _____

When did this situation or concern first begin? _____

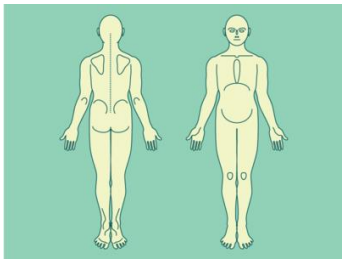
Have you experienced this type of discomfort before? ◻ Yes ◻ No

Have you seen another health care provider for this? ◻ Yes ◻ No Who: _____
Results:

Tell us more about your health concern(s):

Please describe the location of your discomfort: _____

Please circle the area on the chart below.



Character of your discomfort:
Are you experiencing: ◻ pain ◻ numbness ◻ tingling ◻ aches
Is your pain: ◻ sharp ◻ dull ◻ soreness ◻ throbing ◻ Shooting
Do you feel: ◻ swelling ◻ cramping/Gripping ◻ stiffness ◻ burning

On a scale of 1-10 (10 most), what is your pain level: 1 2 3 4 5 6 7 8 9 10

How often are the complaints present?

◻ Constant (100%) ◻ Frequent (51-75%) ◻ Occasional (26-50%) ◻ Intermittent (25% or less)

Is this related to an ◻ auto accident ◻ injury on the job ◻ other injury_____

Have you done anything for or received any advice or treatment for this issue? ◻ Yes ◻ No

Explain: _____

Has it helped? ◻ Yes ◻ No Result: _____

What activities aggravate your condition/pain? _____

What activities alleviate your condition/pain? _____

Is the condition worse during certain times of the day? ◻ Morning ◻ Night ◻ Other:_____

Does it affect your: ◻ daily activities ◻ work ◻ relationships ◻ mood ◻ exercise ◻ sleep

Are there any other health concerns that are important to you? _____

Have you seen any other health care providers for this condition?

◻ Osteopath ◻ Acupuncturist ◻ Massage Therapists ◻ Reflexology ◻ Rolfing ◻ Nutritionist

◻ Other: _____

Have you been to a chiropractor before? ◻ Yes ◻ No If yes, last adjustment Date: _____

Have you had a massage before? ◻ Yes ◻ No Last Massage: _____

Have you ever been diagnosed by any other health care providers? ◻ Yes ◻ No Diagnosis: _____

Have you chosen to accept these diagnoses? ◻ Yes ◻ No

Have any of your organs been removed? ◻ Yes ◻ No (◻ Tonsils ◻ Wisdom teeth ◻ appendix ◻ _____)

Have you had any of the following?

◻ Falls ◻ Head Injuries ◻ Broken Bones ◻ Dislocations ◻ Surgeries ◻ Car Accidents

Dates and details if any checked: _____

Anything else that you like to share that we have not asked? _____

What positions do you sleep in? ◻ Back ◻ Side lying ◻ Stomach ◻ Arms above head

Do you ride a bicycle? ◻ Yes ◻ No

Is your car: ◻ Automatic ◻ Manual

How do you exercise? ◻ Cardio exercises ◻ Yoga/ Acroyoga/ Aerials ◻ Dance ◻ Daily Movement

Do you: ◻ Smoke ◻ Drink Alcohol ◻ Energy drinks ◻ Drink Coffee ◻ Execs Sugar ◻ Drink Soda

Supplements or Medications

Please list Medications and herbal medicine and the reason for taking them:
Medications:_____
Supplement:_____
Herbal Medicine_____
Other: _____
Do you take probiotics ☐Yes ☐No Other forms of Probiotics:_____
Do you take Enzymes ☐Yes ☐No
Other digestive Aids? _____
When was the last time you took antibiotics (Natural antibiotics)? _____

For Women Only

Are you pregnant? ☐ Yes ☐No If yes, how far are you? _____
Are you nursing? ☐Yes ☐No
Are you taking birth controls? ☐Yes ☐No What Kind? _____
Have you had any abortions or miscarriages? ☐Yes ☐No When? _____
Are your periods regular? ☐Yes ☐No

Digestive Health

Do you experience digestive discomfort?
☐ Gas ☐ Bloating ☐ Burning ☐ Flatulence ☐ Pain after eating ☐Acid reflux
☐ Constipation (bowl movement 1/day or less) ☐ irritable bowl syndrome ☐ Hives ☐ Acni
Bowl movement habits? ☐3+times/day ☐ 1-2 times/day ☐ Every other day ☐Two or less/week
How much water do you drink each day? ☐ 1-3 glasses ☐4-7 glasses ☐ 8+ glasses
What color is your urine most often? ☐ Amber/brown ☐ Dark yellow ☐ Light yellow ☐ Clear ☐Pink

Health History (P) for past and (N) for Now

___ AIDS/HIV
___ Alcoholism
___ Allergies
___ Anemia
___ Anorexia/ Bulimia
___ Appendicitis
___ Arthritis _____
___ Asthma
___ Athlete's foot
___ ADD/HDD
___ Blood Pressure High/Low
___ Blood Disorder _____
___ Bowl or Bladder changes
___ Bipolar Disorder
___ Cancer
___ Cataracts
___ Cold/Flu Frequently
___ Constipation
___ Concussion/Head Injury
___ Dental/Jaw issues
___ Depression
___ Digestive
___ Dizziness/Vertigo Problems
___ Diabetes
___ Ear/ Hearing Issues
___ Eye Issues
___ Emphysema
___ Epilepsy
___ Fatigue
___ Fractures
___ Gout
___ Heart Disease
___ Headaches
___ Hepatitis
___ Hernia
___ Herniated Disk
___ Herpes
___ High Cholesterol
___ Infection
___ Kidney Disease
___ Liver Disease
___ Menstrual Problems
___ Migraine
___ Miscarriage
___ Multiple Sclerosis
___ Numbness & Tingling
___ Neck/ Lower back problems
___ Osteoporosis
___ Pacemaker
___ Pneumonia
___ Polio
___ Prostate Problem
___ Rheumatoid Arthritis
___ Respiratory Disease
___ Reproductive Disorders
___ Schizophrenia
___ Sinus Problems
___ Skin Conditions
___ Stress/Anxiety
___ Stroke
___ STDs _____
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Tumors or Growths
___ Ulcers
___ Urinary Tract Infection
___ Vaginal Infections
___ Weight Changes

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How would you rate your quality of life?

1. Poor 2. Fair 3. Average 4. Good 5. Excellent

Overall: How I view my over-all wellbeing, _____.
Physical: In my relationship to my body, _____.
Emotional: In my relationship to my Emotions, _____.

Spiritual: In my relationship to my spirituality, _____.

Mental: In my relationship to my mind, _____.

Family: In my relationship with my family, _____.

Friends: In my relationship with my friends, _____.

Intimate: In my relationship with my significant other, _____.

Sensuality: In my relationship to my body and my need for sensuality, _____.

Children: In my relationship with my children, _____.

Co-workers: In my relationship with my co-workers, _____.

Career Health: In my career, _____.

Social Health: In my social life, _____.

Life Enjoyment: In my life enjoyment and play time, _____.

Financial Health: Financially, _____.

Communication: In my ability to communicate clearly to others, _____.

Stress: In my ability to deal with stress, _____.

Food: In my relationship to food _____.

Exercise: In my body's relationship to movement and exercise, _____.

Life: In my overall attitude towards life, _____.
In my overall life experience, _____.

I, _____, have answered the above questions to the best of my knowledge. Based on the information provided, I grant Dr. Nima Mahallti permission to assess, locate, and release my subluxation patterns.

Signature: _____ Date: _____

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Consent Form

When a participant seeks chiropractic health care and we accept a participant for such care, it is essential for both parties to be working toward the same objectives. It is important that each participant understands both the objectives and the methods that will be used to attain said objectives. This will prevent any confusion or disappointment. You have the right, as a participant, to be informed about the condition of your health and the recommended care and management to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease
or infirmity. Therefore, symptoms are NOT a valid measure of health.
Subluxation is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body's overall, healthy performance.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce subluxation. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.
If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I have read and understand all of the above statements. I _____, hereby authorize Dr. Nima Mahallati D.C, CMT to render chiropractic services to me. I understand that I am not being treated for or diagnosed with any other named conditions despite my initial reason for presenting at this office. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payments which are paid in full each visit.

Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

1. Holistic Chiropractic's Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ('PHI') necessary for HCC to provide treatment to me, and necessary for HCC to obtain payment for that treatment and to carry out its health care operations. HCC explained to me that the Privacy Notice will be available to me in the future at my request. HCC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing consent.

2. HCC reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law and I will be informed of any revisions.

3. I understand that, and consent to, the following communications that will be used by HCC:
a) telephoning, text messeges and leaving a message on my answering machine or with the individual answering the phone; b) a card, letter, or other written information mailed to me at the address provided by me; c) sending an electronic mail to the address provided by me.
[Please note: email and text messages are not secure, protected forms of communication. By signing below you are acknowledging your choice to use them to communicate PHI.]

4. HCC may use and/or disclose my PHI in order for HCC to treat me and obtain payment for that treatment, and as necessary for HCC to conduct its specific health care operations.

5. I understand that I have a right to request that HCC restricts how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, HCC is not required to agree to any restrictions that I have requested. If HCC agrees to requested restrictions, then the restriction is binding on HCC.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent the HCC has already taken action in the reliance on this consent.

7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, HCC will not treat me. I further understand that if I revoke this consent, at any time, HCC has the right to refuse to treat me.

8. HCC may maintain a directory of and sign-in log of individuals seeking care and treatment in this office. This information may be seen by and is accessible to others who are seeking care or services in HCC's practice.

9. Visits and spinal adjustments are performed in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. If you have comments or information you wish to share privately when you come into the adjustment room please inform the doctor or staff and we will accommodate your needs. I acknowledge that I have received a copy of HCC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted at the front desk. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with Dr. Nima Mahallati. Your signature below is acknowledgment that you have received the Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand. .

Patients 's Name (Print): _____

Signature: _____ Date: _____