CASE HISTORY

Patient History

Name_____ Date_____

Address_____City_____State_____ Zip_____

Email Address _____Cell #(_____)_____

Work # (_____)_____Home #(_____)_____ Date of Birth_____ Age_____

Referred by_____Social Security #_____

Occupation_____Employer_____

Marital Status S M D W Spouse Name_____ Have you ever received Chiropractic Care? Yes No

If yes please explain

Current Health Habits:

Did/do you smoke?	Y N	_____
Did/do you drink alcohol?	Y N	_____
Diet, do you eat healthy foods?	Y N	_____
Have you been in accidents/trauma?	Y N	_____
Have you had surgery?	Y N	_____
Drugs, prescription, OTC, recreational?	Y N	_____
Dental problems?	Y N	_____
Eye problems?	Y N	_____
Hearing problems?	Y N	_____
Exercise regularly?	Y N	_____
Did/do you have occupational stress?	Y N	_____
Drive? Daily time spent driving	Y N	_____
Physical stress?	Y N	_____
Emotional/Mental stress?	Y N	_____
Hobbies/Sports injuries?	Y N	_____
Do you sleep well, hours of sleep?	Y N	_____
Sleeping posture? O side O stomach O back		_____

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:

Major_____

Pain or Problem started on_____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____

Does this pain shoot, radiate, or travel in your body? Where?_____

Are you experiencing numbness or tingling in any area of your body? Where?_____

Since it began, is it: O Same O Better O Worst

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is this condition worse during certain times of the day?_____

Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____

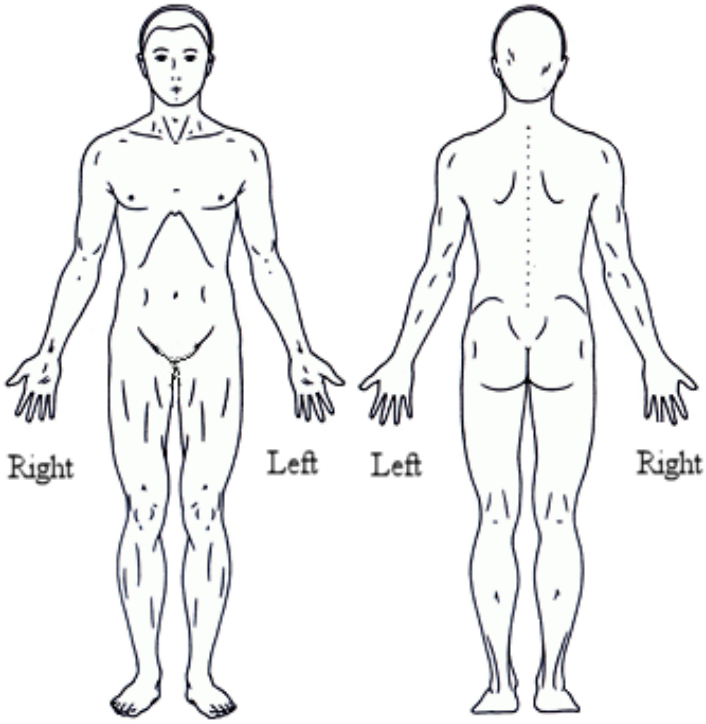
Is this condition progressively getting worse?_____

Other Doctors seen for this condition_____

Any home remedies? _____

Please Circle where you are at: (No Complaint / Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Using the symbol below,
mark on the pictures where you feel pain.



Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:

Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for any condition?_____

What Medications are you taking?_____

How long?_____ Have you had surgery?_____ What?_____ When?_____

What side effects have you experienced from the drugs and surgery?_____

Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____

NOTICE OF PRIVACY PRACTICES

Dr. Eric Nilsen / Dr Salvadore Kerkar

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. Eric Nilsen & Dr Salvadore Kerkar 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 associate with Dr. Eric / Dr. Sal."

"It is our policy to provide a substitute health care provider, authorized by Dr. Eric / Dr. Sal 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 Dr. Eric / Dr. Sal for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized bill 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 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.
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 all our office in the event you need to cancel or reschedule."

"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 the event."

Change of Ownership
In the event that Dr. Eric / Dr. Sal is sold or merged with another organization, your health information/record will become 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 Dr. Eric / Dr. Sal is not required to agree to the restriction 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 a right to inspect and request your health information.
- You have the right to request that Dr. Eric / Dr. Sal amend your protected health information. Please be advised, however, that Dr. Eric / Dr. Sal 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 the right to receive an accounting of disclosures of your protected health information made by Dr. Eric/ Dr. Sal.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Dr. Eric / Dr. Sal 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, Dr. Eric/ Dr. Sal is required by law to comply with this Notice.

Dr. Eric/ Dr. Sal 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 any questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Eric/ Dr. Sal by calling this office at (310) 327-1325. If Dr. Eric/ Dr. Sal 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 Dr. Eric / Dr. Sal has handled your health information should be directed to: Dr.Eric / Dr. Sal by calling this office at (310) 327-1325. If Dr. Eric Nilsen or Dr. Salvadore Kerkar 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 Notice of Privacy Practices and understand my rights contained in the Notice. By way of my signature, I provide Dr. Eric/ Dr. Sal with my authorization and consent to use and disclose 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

Informed Consent to Chiropractor Treatment

As with any HealthCare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) **Some patients may experience some stiffness or soreness following the first few days of treatment.**

2.) **Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance**

3.) **I will make every effort to screen for any contraindications to care; However, of you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.**

4.) **Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.**

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted)

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature **Patient Name (Please Print)**

_____ _____

Witness Signature

_____Date_____

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Parent or Guardian Signature Date

*Waiver and Assumption of Risk

*I, _____, Customer, of Crush It Marketing Inc., City of Carson, State of California , voluntarily sign this waiver and assumption of risk in favor of Steven Sanchez, Owner, of West Coast Sports & Fitness Center City of Carson, State of California , in consideration for the opportunity to use the owner's facilities and/or the opportunity to receive instruction from the owner or the owner's employees, independent contractors and/or to engage in the activities sponsored by the owner.

*I understand that there are certain risks and dangers associated with the activity and use of the facilities and that these risks have been fully explained to me. I fully understand the danger involved. I fully assume the risks involved as acceptable to me and I agree to use my best judgment in undertaking these activities and follow all safety instructions. I waive and release the owner, owner's employees and independent contractors from any claim for personal injury, property damage, or death that may arise from my use of the facilities or from my participation in the activities or instruction.

IF CHILDREN ARE BROUGHT IN WITH PARENTS DURING EXERCISE SESSION PARENTS WILL TAKE FULL RESPONSIBILITY OF CHILD WHILE AT WEST COAST SPORTS & FITNESS CENTER. I RELEASE, DISCHARGE, WAIVE AND COVENENT NOT TO SUE CRUSH IT MARKETING INC, AND ALL THEIR RESPECTIVE AGENTS IF AN INCIDENT OCCURS FOR ANY REASON . I AS A PARENT TAKE FULL RESPONSIBILITY

*I have carefully read this Waiver and Release and fully understand its contents. My parent or legal guardian has completely reviewed this Waiver and Release, understands and consents to its terms, and authorizes my participation by his/her signature below. I am aware that this is a RELEASE OF LIABILITY and a contract between me and the persons and entities mentioned above and I sign of my own free will.
**Photographic Release* : Digital photographs and video are taken of many West Coast Sports & Fitness Center Athletes & Fitness Clients. I hereby give WCSF Center permission to use such photographs and/or video for public displays, training material and/or media releases. I understand these photographs and/or video images will be for news, training and/or Information purposes only.

- Instructors are in charge at all times.
- Participation is allowed only when following the guidelines of the instructors, and always under their supervision.
- Sign-in is required of all participants (even those with an Open Gym waiver on file)
- Only WCSF Center Instructors may assist participants with activities
- No horseplay, rough housing, running, pushing, misuse of equipment, or dangerous activities will be tolerated.
- No food or drink is allowed on the gym floor at any time! Please enjoy drinks and snacks in our lobby area.

*If you feel that there is **ANY** health reason why you should not participate in physical activity, check with your doctor before beginning this program. Provision to this agreement is governed by California law and any disputes shall be resolved in Carson, California

Participant Signature:_____

Print Name:_____ Date:_____

Parent/Guardian Signature:_____

Print Name:_____ Date:_____