NEW PATIENT PAPERWORK

Dear Patient,

Welcome! And thank you for choosing us as one of your health care providers.

HOW THE PROCESS WORKS:

STEP 1:

During your initial consultation we will review your health history and make recommendations for lab tests that are appropriate for your specific health issues.

STEP 2:

Once you have completed your lab tests, we will explain the meaning of your test results to you in a follow up consultation. We will create an individualized therapeutic program for you including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

STEP 3:

Subsequent consultations are scheduled to monitor your progress. We will also design an ongoing wellness program to be reviewed and updated with our staff at no charge every six months.

We invite you to contact us via email or phone should you have any questions during the course of your treatment.

We look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

New Patient Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize you to release my personal medical information to me.

Patient's Signature: ____ Date: _________________________

Name:					Date:
Address:				Country:	
City:		State:		Zip/Postal Code:	
Home Phone:	Work Phone:			Fax:	
E-mail:			Cell Phone:		
Please mark your preference for occasional follow up communication from our office: _____Email _____Phone					
Age:	Birth date:		No. Children:		
Sex: Male Female		Marital status M S W		D	
Occupation:		Employer:		Years Employed:	
Spouse's Name:				Occupation:	
Person responsible for this account:				Referred by:	
What is your major complaint?					
Other complaints?					
What are your overall health goals once your complaints are resolved?					
How long has it been since you really felt good?					

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight ______ Height _______ Blood Pressure (if known) _____________ % Body Fat (if known) ________

1. Are you presently taking any medications, nutritional supplements or vitamins? ____________________

please list (attach sheet if necessary)

____

2. In the past, have you used birth control pills and/or antibiotics?__________________________________

a. For how long?____

3. If you have fillings, please list material(s) used:____

4. Do you presently, or have you ever had any of these conditions? (check box)

Anemia	Frequent headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average?____

6. Do you have any food allergies, sensitivities or restrictions?____

____

7. Do you smoke, drink alcohol or use recreational drugs?____

a. How much, how often?____

b. How often do you drink caffeinated beverages?____

8. Please list foods you tend to overeat or crave (sweets, breads, fatty foods, meats, milk, etc.):

____

9. Are there foods that you eat on a daily basis, almost daily basis?____________________________________

____

a. Do you "miss" these foods if you do not eat them?____

10. Write briefly about your weight gain/loss history:____

____

a. What do you feel triggered your weight fluctuation? (Check box)

heredity stress eating habits boredom

b. Was your weight gain/loss: (Check box)

sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity:________________________________

____

12. What methods have you tried to lose/gain weight?____

____

13. How is your energy level?____

a. Are there times in the day that you feel best?_______________________worst?_______________________

14. Are you happy in your life right now?____

15. What are your main sources of stress____

____

16. How do you deal with your stress?____

____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes_____ No_____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes_____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes_____ No_____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert.

Yes_____ No _____

e. Now and then I think I am a secret eater. Yes _____ No_____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes_____ No_____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes_____ No_____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No_____

i. I feel shaky if I don't eat on time or if I don't snack. Yes_____ No_____

j. I often find myself irritable or angry. Yes_____ No_____

18. Check off any of the following that have applied to you within the last 30 days:

Do you feel nauseous?	Do you have abdominal/intestinal pain?
Do you have bloating?	Do you get bloated after meals?
Do you get heartburn?	Do you have diarrhea?
Do you have constipation?	Do you travel outside of the U.S.?
Do you have gas?	Are your stools compact/hard to pass?
Do you belch following meals?	Do you have gurgles in your stomach?
Do your bowel movements alternate between constipation and diarrhea?	

24. In your estimation, how physically fit are you right now?

Unfit_____ Below average_____ Average _____ Above average_____ Very fit_____

25. How often do you exercise? ____

a. What is your regimen?____

____

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

____

27. What are your fitness goals? (check all that apply)

General fitness endurance	Muscle toning
Weight loss/maintain weight	Muscle strengthening
Osteoporosis prevention	Muscular coordination/balance
Specific sport enhancement	Other_____________________________________
Flexibility	

28. Surgeries, starting with most recent:____

29. Hospitalizations:____

30. Briefly describe where you have lived since childhood:_____________________________________

____

____

31. What is your heritage? (Irish, German, Spanish, etc.) ____

32. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:			**Do you often:**		
Satisfactory	Now	Past	Feel depressed	Now	Past
Boring	Now	Past	Have anxiety	Now	Past
Demanding	Now	Past	**Do you often:**		
Unsatisfactory	Now	Past	Have irrational fears	Now	Past
Do you worry over:			Feel upset	Now	Past
Home life	Now	Past	Feel things go wrong	Now	Past
Marriage	Now	Past	Feel shy	Now	Past
Children	Now	Past	Cry	Now	Past
Job	Now	Past	Feel inferior	Now	Past
Income	Now	Past	**Have you:**		
Money problems	Now	Past	Seriously considered suicide	Now	Past
			Attempted suicide	Now	Past

POLICIES AND PROCEDURES

(please retain for your records)

New Patients:

First Appointment

Your first consultation will be 45 minutes – 1 hour. During this time we will determine the appropriate lab tests you should order to address your specific health concerns.

1. Payment is due at time of consultation
2. Methods of payment are: Check or money order (in advance) Visa, MasterCard or American Express.
3. All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments:

- Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time.
- We encourage you to book your appointments 2 weeks in advance.
- As a courtesy to you, our office will call you to confirm your appointment one day in advance. You may also receive a reminder via email.

Lab Tests:

- The results of your lab test(s) will be sent to us 2 to 4 weeks after mailing your specimens to the lab.
- We will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.

Cancellations:

- If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

Returned Products:

- PRE-APPROVAL is REQUIRED on ALL RETURNS!!
- Refrigerated items CANNOT be returned
- 15% restock fee of purchase price less shipping and handling may be refunded on unopened and non-refrigerated items
- No supplement returns will be accepted after 30 days on all regularly stocked items. Special

orders CANNOT be returned!

- Prepaid tests can be returned for credit within one year of purchase.

Important Notes:

- We do not service medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911!
- Please contact the office if you are not clear on any of our policies or procedures.

I ____ have read and understood the Policies and Procedures. (please print name)

Date____

Signature____

Please complete this form if you would like us to share information about your progress with another person.

Authorization to Release Medical Information

To: ____

Address: ____

I, ____ request the following information:

_____Test results ______History ______Records ______Diagnosis

_____Treatment ______Reports ______Progress

Concerning my: ______Accident _____Injury _____Illness

Other ____

To be released to: ____

(Name of Practitioner, Doctor, family member etc.)

Address: ____

Fax:____

For the purpose of: ____

(Specify)

According to Section 1795 of the California Health and Safety Code, these records must be provided within 15 days of receipt o this notice.

Signed: _____________________________________ Date: ____________________

______Patient ______Spouse ______Parent ______Guardian

INFORMED CONSENT

I, the undersigned, have voluntarily requested that Dr. John Marian and/or their staff assist me in the management of my health concerns. I understand the Doctors of Chiropractic & the Chiropractic clinic itself offer services are a form of conservative and alternative health care.

Medical doctors, Doctors of Chiropractic and Osteopaths who perform manipulation are required by law to obtain your informed consent before starting treatment.

I ______________________, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manual therapies, manipulations, and/or adjustments involving the movement of the joints and soft tissues. Physical therapy, home exercises, and nutritional supplements/dietary recommendations may also be used.

Routine chiropractic examination and treatment involves some of the following methods:

- Observation: General assessment/appraisal in all postures.
- Inspection: Viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, back, and side. All symptomatic (painful) areas of complaint may be viewed if necessary.
- Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.
- Palpation: This means a doctor will touch you feeling for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
- Percussion: Using a rubber hammer to tap on bones or tendons.
- Orthopedic/Neurological testing: These are standard tests to assess your neuromusculoskeletal systems.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Risks from Treatment

Soreness: I am aware that like exercise, it is common to experience muscle soreness in the first few treatments. I understand that this is a normal response to treatment and agree to notify the Doctor immediately if I experience pain that feels beyond minor muscle soreness.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform the Doctor if you experience any of these symptoms.

Manipulations/Adjustments: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury from manipulations/adjustments. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution to avoid injury.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Modalities: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.
A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve those benefits.

I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other person's of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain and inflammation. I am aware that long-term use or overuse is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have read to me the above explanation of chiropractic treatment. I have made my decision to undergo care voluntarily and freely. To attest my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Signature of Patient (Legal Guardian if a minor):
____

Date: ____________________

Dr. John Marian D.C.

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

In the course of your care as a patient of Dr. John Marian we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including 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 an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, phone number, email address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use of disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required 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 our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

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.

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 regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to you health information. Requests 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 protected health information therein. We are also required to provide you with this notice of our privacy practices with the 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 change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. John R Marian.

If you would like further information about our privacy policies and practices please contact: Dr. John R Marian

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of January 1, 2016. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

______________________________ ________________________ _______

Name (Printed please) Signature Date

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

______________________________ _________________________ _______

Personal Representative Printed Personal Representative Sign. Date

____

Description of the authority to act on behalf of the patient.