In Line
Chiropractic
Sports &
Wellness
2100 Lakeshore Ave., Ste. E, Oakland, CA 94606

REGISTRATION AND HISTORY

Patient Information

Date ____________ Sex: Male / Female
Name ____________
Address ____________
City ____________
State ________ Zip ________

E-mail ____________

Birthdate ____/____/____ Age ________

(Please Circle below)
Married / Widowed / Single / Divorced / Partnered / Minor

Occupation ____________
Patient Employer/School ____________
Employer/School Address ____________
____
Employer/School Phone ____________
Spouse/Partner's Name ____________
Birthdate ____________
SSN ____________

Spouse/Partner's Employer ____________
Whom may we thank for referring you?
Name: ____________

Insurance

Who is responsible for this account? ____________
____
Relationship to patient ____________
Insurance Co. ____________
ID# ____________
Group # ____________
Is there additional insurance coverage? Y / N

Assignment and Release

I certify that I, and/or my dependents have insurance coverage with ______________________
and assign directly to Abigail A. Irwin, DC, DACBSP
insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment and determining benefits.

Signature: ____________
Print Name: ____________
Date: ____________ **Relationship:** ____________

Phone Numbers

Home Tel. # ____________ Wk/Cell # ____________
Best number to call: ____________

IN CASE OF EMERGENCY, CONTACT

Name: ____________ Relationship: ____________
Home Tel. # ____________ Wk/Cell # ____________

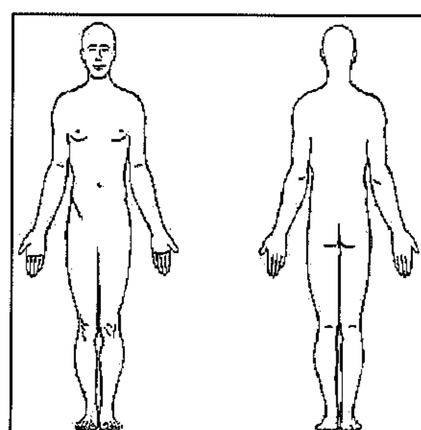
Accident Information

Is this condition due to an accident? Yes No
Date of Accident: ____________
Type of Accident: Auto Work Home Other
To whom have you reported accident to?
Auto Insurance Employer Work.Comp. Other
Attorney's Name: ____________

Patient Condition

Reason for visit: ____________
When did your symptoms appear? ____________
Is this condition getting progressively worse? ____________

Mark an X on the picture where you are having symptoms →



Rate the severity of pain on a scale of:
1 (least pain) to 10 (severe pain) ____________

Type of pain: (Please Circle) Sharp Dull Throbbing Numbness Stiffness Swelling Burning Shooting Tingling Cramps Aching Other: ________

How often do you have this pain? ____________

Is it constant or does it come and go? ____________

Does it interfere with your: (Please Circle) Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: (Please Circle)
Sitting Standing Walking Bending Lying Down Other

____
Patient Initials

Health History

What treatment have you already received for your condition? (Please Circle)
Medication Surgery Physical Therapy Chiropractic Services Massage Acupuncture
Other None

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Date of last:

Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Please circle any of the following conditions that you have had:

AIDS/HIV	Diabetes	Liver Disease	Rheumatoid Arthritis
Alcoholism	Emphysema	Measles	Rheumatic Fever
Allergy Shots	Epilepsy	Migraine Headaches	Scarlet Fever
Anemia	Fractures	Miscarriage	Sexually Transmitted Disease
Anorexia	Glaucoma	Mononucleosis	Stroke
Appendicitis	Goiter	Multiple Sclerosis	Suicide Attempt
Arthritis	Gonorrhea	Mumps	Thyroid Problems
Asthma	Gout	Osteoporosis	Tonsillitis
Bleeding Disorders	Heart Disease	Pacemaker	Tuberculosis
Breast Lump	Hepatitis	Parkinson's Disease	Tumors, Growths
Bronchitis	Hernia	Pinched Nerve	Typhoid Fever
Bulimia	Herniated Disk	Pneumonia	Ulcers
Cancer	Herpes	Polio	Vaginal Infections
Cataracts	High Blood Pressure	Prostate Problem	Whooping Cough
Chem. Dependency	High Cholesterol	Prosthesis	Other_____
Chicken Pox	Kidney Disease	Psychiatric Care	_____

Services that you are interested in: (please circle)
Chiropractic Care Physiotherapy Rehabilitative Service Wellness Nutritional Services
Massage Therapy Other _____

Exercise	**Work Activity**	**Habits**	
(please circle)	(please circle)	(please circle)	
Light	Sitting	Smoking	Packs/Day _____
Moderate	Standing	Alcohol	Drinks/Week _____
Heavy	Light Labor	Coffee/Caffeine Drinks	Cups/Day _____
Daily	Heavy Labor	High Stress Level	Reason _____

Are you pregnant? Yes No Due Date _____

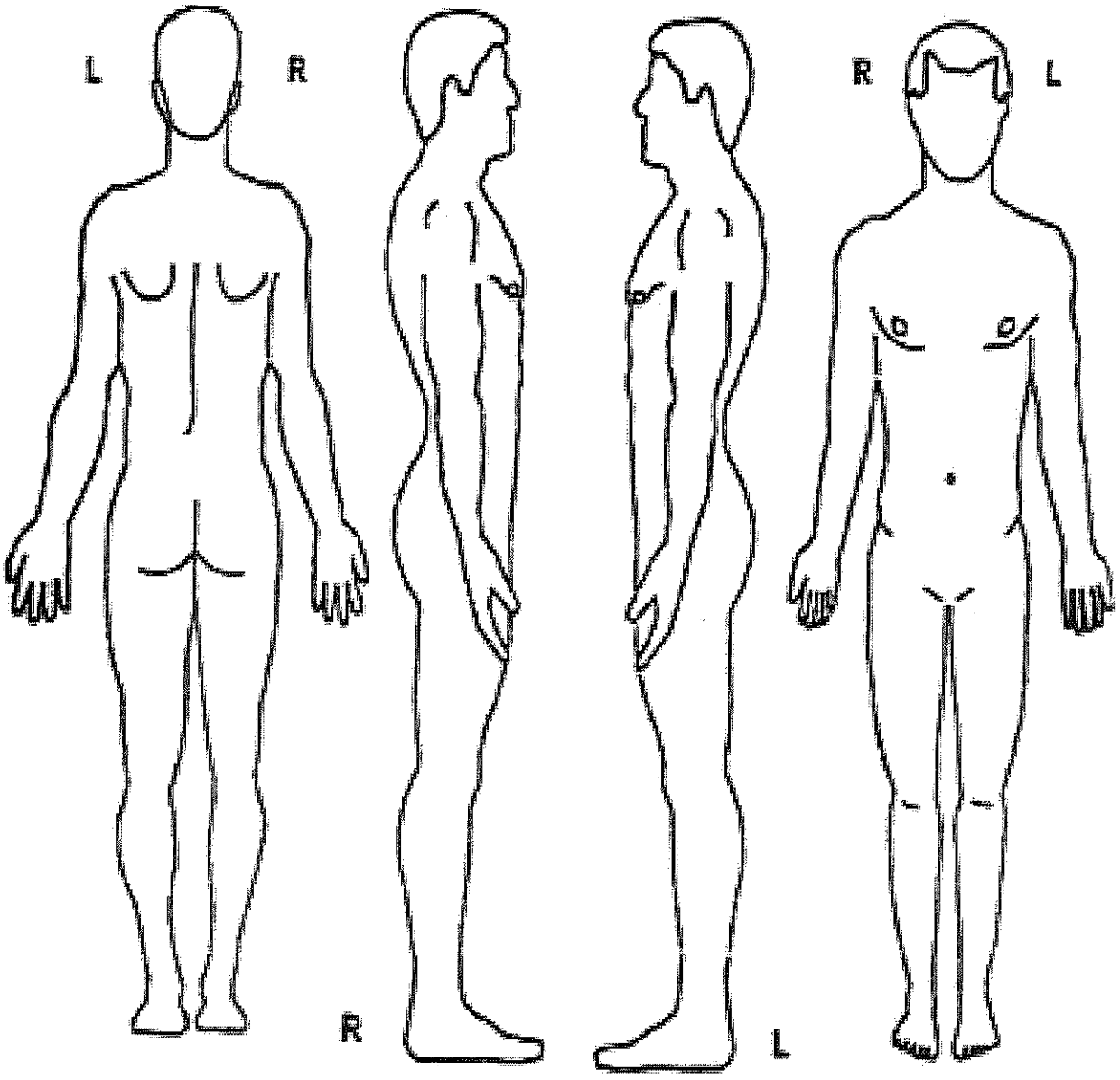
Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	**Allergies**	**Vitamins/Herbs**

_____ ___/___/___
Patient Signature **Date**

PAIN DRAWING

Name: _____ **Date:** _____



Mark the figures above with one or more of the descriptors below in the area you feel pain.

A – Ache	**P – Pins & Needles**
B – Burning	**S - Stabbing**
N – Numbness	**O – Other (please describe)** _____

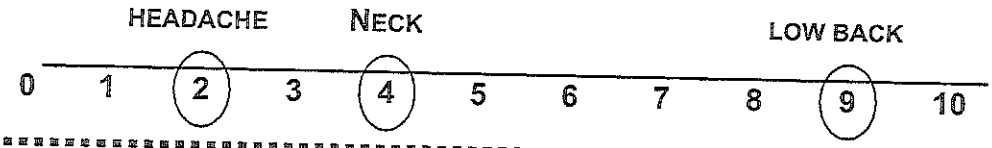
QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Number _____ Date _____

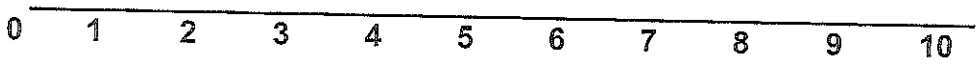
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

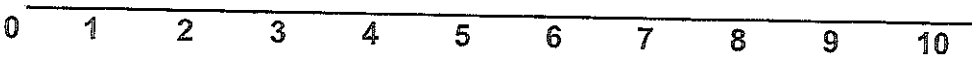
EXAMPLE:



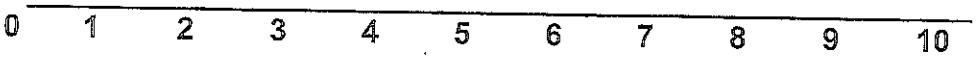
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

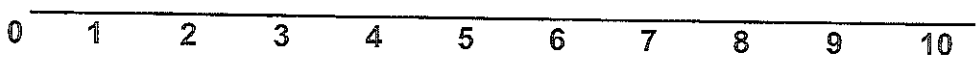


3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

In Line Chiropractic
Dr. Abigail Irwin • Dr. Vu Tran
2100 Lakeshore Avenue • Oakland, CA 94606

Patient Name: _____
(Please print.)

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, electric modalities, massage therapy, and soft tissue manipulation, on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) chiropractic named above and/or other licensed doctors of chiropractic who now or in the futurework at the clinic or office named above.

I have had an opportunity to discuss with the doctor(s) of chiropractic above, and/or with other office or clinic personnel, the nature and purpose of chiropractic treatments and other procedures provided at the above named facility, including:

1. The proposed procedure(s)
2. The potential benefits
3. The known risks of the procedure(s)
4. Common alternatives to the procedure, including refusal of care and the associated risks of that refusal

I understand that results are not guaranteed.

I understand and am informed that the practice of chiropractic presents some known risks associated with treatment, including but not limited to fractures, disc injuries, strokes, dislocations, sprains, and even mild burns associated with electric modalities that emit heat. I do not expect the doctor to be able to anticipate and explain all perceived risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the examination and treatments to provide procedures which he/she feels is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the treatment and options, and by signing below I agree to the treatment procedures the doctor(s) deem necessary for my current condition. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient signature: _____ Date:_____

Doctor signature: _____ Date:_____

In Line Chiropractic Sports and Wellness

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the doctor's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information to support the business activities of your doctor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, or conducting and arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, FDA requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted Uses and Disclosures Will be made only with your consent, authorization, or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your doctor or the doctor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law and prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your doctor is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have a right to obtain a paper copy of this notice from us.

Upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your doctor amend your protected health information.

If we deny your request for amendment, you have a right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

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 ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.
Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature: _____ Date:_____

In Line
Chiropractic
Sports &
Wellness

FINANCIAL POLICY

Payments

I understand that payments and/or deductible, co-insurance or co-payments are due at the time of service. In Line Chiropractic accepts cash, check, Visa, MasterCard and Discover. Checks should be made out to my **Dr. Abigail Irwin** for all services, regardless of practitioner.

Cancellation policy

In the event I should need to cancel or reschedule an appointment, I understand that 24-hours notice is required. I understand and agree to pay the following fees for late cancellations, missed appointments or no-shows: **$50 for Chiropractic and $100 for Massage Therapy.**

Insurance Billing

If my insurance policy covers Chiropractic care, I understand that as a courtesy to me, In Line Chiropractic will call and confirm benefits and file claims on my behalf. However, any notification of benefits is ***not*** a guarantee of payment by my insurance company and I understand that ***I am responsible for any and all charges not paid in full.*** I will immediately notify In Line of any additions or changes to my coverage as soon as it is effective. This will allow In Line to verify my benefits and reduce the likelihood of denied claims.

Discount Packages

For patients paying out-of-pocket, In Line offers Chiropractic and Massage Therapy packages at a discounted rate. I understand these packages do not expire and are ***non-refundable once purchased.*** However, I may transfer unused services to another patient or keep as a credit toward other goods and future services at In Line.

Outstanding Balances

I understand I will receive a statement every sixty days regarding any outstanding balance. It is In Line's goal to communicate financial obligations as clearly and simply as possible in order to focus more fully on my wellbeing. I know I can contact In Line any time with questions or concerns about my account.

_____ _____

Patient Name (Please Print) ***Patient signature***

_____

Date

2100 Lakeshore Avenue, Suite E • Oakland, CA 94606

Tel. (510) 893-1577 • Fax. (510) 893-8907

Revised 09/01/2017

PAIN AND FUNCTION INTENSITY SCALE

Each time you come in to In Line Chiropractic for treatment, we will ask you to rate your pain and function. Please refer to this sheet for information on how to do so.

	None	Mild	Moderate	Severe
Scale	0	1 2 3	4 5 6 7	8 9 10
Pain Level	No pain	Annoying pain only	Pain level causes me to slow down.	Pain levels limit my ability to perform some activities.
Pain during activity		Some discomfort	Performing activities takes longer or I need more breaks	Inability to do certain activities.
Ability to perform activity		Able to perform all activities	I am unable to perform demanding activities	Affects my ability to sleep
How does the pain feel?		Ache, dull, soreness, stiffness	Very sore, limited motion	Sharp or stabbing pain

In Line Chiropractic
2100 Lakeshore Ave., Suite E ~ Oakland, CA 94606 ~ 510.893.1577 ~ Fax: 510.893.8907 ~ www.inlinedc.com

After Your First Adjustment

1. Take it easy for the rest of the day (for at least a few hours) to let your body get used to the adjustment. For exercise, take a short walk.

2. Make a note of any changes in your symptoms.

3. Drink at least 1-2 extra glasses of water today.

4. Ice the problem area for 20 minutes every hour, as needed. Put at least one layer of paper towels between the ice and your back. Do not use a thick terry towel, as it maybe too much insulation.

5. Occasionally, people may experience soreness after the first adjustment. Usually ice (see above) will take care of this. If you experience discomfort and are concerned, please do not hesitate to contact us.

We welcome you to ***In Line Chiropractic*** and look forward to our partnership in regaining and maintaining your optimum health!

Nov. 2011