PATIENT INTRODUCTION FORM

Today's Date: _____

Last Name: **MI:** **First Name:**	
Home Address: **City:** **State:** **Zip:**	
Date Birth: Age:	Telephone: Home: Office:
Height: Weight:	Who Referred You to Our Office:
Employer's Name:	Marital Status (Circle): Single, Married, Divorced, Widowed
Occupation:	Name of Family Physician:

Email Address:

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws. Patient confidentiality and privacy/security applies to any **protected health information (PHI).** Signature: _____Date:_____ Expiration Date/Event for Authorization: ☐ No expiration date ☐When treatment has concluded and bills have been paid. ☐ Date: _____	**PRIVACY NOTICE-HIPAA.** I acknowledge that the office, has presented me with a copy of the privacy practices and I have been able to read the practice policies notice that is posted on the waiting room wall. This notice explains how my protected health information (PHI) may be used and what the office responsibilities are regarding my privacy rights. I have been allowed to request a printed sheet of the office's privacy notice. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

IS THIS VISIT RELATED TO:

☐ Work Related Injury/Symptoms	☐ Motorcycle-Bicycle Injury	☐ Non-Injury Pain/Symptoms
☐ Sport or Recreational Injury	☐ Home Injury Symptoms	☐ Check-up Only
☐ Motor Vehicle Crash Injury	☐ School/Employment Physical	☐ Other (Describe):

HEALTH-MEDICAL INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	☐ Yes, ☐ No If yes, we need a copy of the card
If yes, indicate Insurance Company Name (Need copy of card).	Insurance Name: _____ Address: _____ Telephone: _____
Are you the insured person or dependent (wife/husband/child)?	☐ Insured, ☐ Dependent
If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number, and the company/business name of the insured employer in order to do billing.	Name of Insured Person: _____ Social Security Number: _____ Insured Date of Birth: _____ Name of Insured Employer:_____
What is your co-payment amount for each visit?	Amount: $ Percentage: %
Do you have a health insurance deductible for chiropractic?	☐ Yes, ☐ No Deductible $ _____ Have you met deductible yet?
Specific chiropractic health insurance benefits	Number visits per year #_____. Amount per year: $_____

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES FOR AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS.

Patient Signature and Date	I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health/automobile insurance carrier. Minors must have parent's signature.

Doctor's Name/Address: Dr. Dhesi, FCG Healthcare, 1081 Market Place, Suite 100, San Ramon, CA 94583

GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	History of poor healing or told that you have a healing disorder?	☐	☐
☐	Smoke cigarettes or use tobacco products?	☐	☐
☐	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	☐	☐
☐	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	History of any disease such as AIDS, Tuberculosis, ALS, Meningitis, etc.?	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	☐	☐
☐	Epilepsy-Seizure-Convulsion history or any other neurological disease?	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	☐	☐
☐	Cancer history or cancer treatment or surgery of any type?	☐	☐
☐	Stroke history (Indicate any suspected mild strokes or transient ischemic attacks)?	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration in the spine?	☐	☐
☐	Have you ever been hospitalized? Why/When:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	☐	☐
☐	Hypertension or high blood pressure? If yes, name of MD seeing:	☐	☐
☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis?	☐	☐
☐	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?	☐	☐
☐	Autoimmune disease, Crohn's disease, ulcerative colitis, muscle diseases, etc?	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

(☐ I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Home/Sports Injury	☐ Lifting Injury	☐ Car Accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches	☐ Neck Pain	☐ Middle Back Pain	☐ Low Back Pain	☐ Shoulder Pain
☐ arm numb/tingling	☐ Arm Pain	☐ Leg Pain/Tingling	☐ Other Pain:	

FRACTURES/BROKEN BONES HISTORY

(☐ I have never had any broken bones). If you have broken/fractured any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone, ribs, or sternum		☐ Pelvis or hip bones	
☐ Arm, leg, hand, or foot bones		☐ Other: List	

PREVIOUS SURGERIES

(☐ I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Abdominal/chest Surgery or Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Liver/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Head/Brain/Spinal Cord/Nerve		☐ Hernia (inguinal or hiatal)	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

When did you have your last physical examination by a medical doctor? Year: _____ Name MD: _____

Patient Name:	Doctor's Name:

FCG HEALTHCARE, 1081 MARKET PLACE, SUITE 100, SAN RAMON, CA 94583 [925]275-9350

GENERAL HEALTH HISTORY (Page 2)

☐ No, ☐ Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, spinal cord, brain, nerves, or other diseases? If yes, please describe:____

_____

☐ No, ☐ Yes **Have you ever been to a Chiropractor before for any condition?**
If yes, Chiropractor's Name/City : _____ Year:_____
List Problem(s) that the Chiropractor treated you for:_____

☐ No, ☐ Yes **Do you have any problems laying face down on an examination table**, including tender chest/breast, level of pain, etc? If yes, why: _____

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Other:	

Did your current symptoms come on? ☐ Suddenly, ☐ Gradually

ARE YOU TAKING ANY MEDICATIONS PRESENTLY?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Blood pressure or Stroke prevention medications	☐ Endocrine-Hormone medications
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:
☐ Diabetic medications	☐ Immunity drugs	☐ Other:

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

☐ Morning is when pain is worse	☐ Bending your back increases pain	☐ Walking increases pain
☐ Afternoon/evening pain worse	☐ Lying down flat increases pain	☐ Standing increases pain
☐ During sleep hours pain worse	☐ Sitting increases pain	☐ Exercise/Stretching increases pain
☐ Standing up from sitting	☐ Poor posture increases pain	☐ Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

☐ Walking	☐ Being flat on your back	☐ Exercise/Stretching
☐ Sitting	☐ Standing	☐ Other:

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

Patient Name:	Doctor's Name:

Form 1010

Patient Intake Form

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check YES or NO to the questions below

YES ☐ NO ☐ Do you have a pacemaker or any other implanted devices?

YES ☐ NO ☐ Are you pregnant?

YES ☐ NO ☐ Do you have cancer?

YES ☐ NO ☐ Are you taking medications that may increase your sensitivity to light?

YES ☐ NO ☐ Have you had a steroid injection in the last 7 days?

Patient Signature _____ Date _____

Print Patient Name _____

Notes:

The ultimate decision to recommend treatment lies with your health care provider.
Speak with your health care provider if you have further questions about therapy treatment.

Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results.

Increased soreness may occur after your first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

☐ I understand the above and consent to treatment

☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

Patient Signature

Date

Print Patient Name

Physician Signature