Patient Information

Date of first visit ________________________

First Name: ______________________ M.I. ____________ Last: ________________________________

Name you would prefer to be called: ____

Address: ____

City:___________________________ ZIP:_____________

Social Security # ____________-_______ - __________ (For Insurance Only)

Gender: ________________________

Your Birthdate: ___________________

Primary phone number: _____________ Secondary phone number: __________________________

Your Email Address: _______________________________

In an emergency, contact: ______________Phone #:___________________

How did you hear about us? ____

____

Are you willing to be an active participant in your health? ☐ Yes ☐ No

Have you ever seen a chiropractor before? ☐ Yes ☐ No

Are you under a medical doctor's care? ☐ Yes: Name______________________ ☐ No

If so, would it be ok for us to contact him/her to coordinate care? ☐ Yes ☐ No

If yes, Phone #: ___________________

Have you ever been in an automobile accident? (if yes explain) ______________________________________

____

Are you currently working? ☐ Yes ☐ No Job title: ____

Hours per week: __________________

Employer Name & Address: ____

At your job, most of the time do you:

☐ Sit? ☐ Stand? ☐ Bend? ☐ Twist

How much do you lift at work?________ ☐ 0-10 lbs? ☐ 10-25 lbs?_________________________

☐ 25-50 lbs? _____________________ ☐ 50 or more lbs? How often? ____________________________

☐ Occasionally? ___________________ ☐ Frequently? ☐ All the time_________________________

Do you use a computer? ☐ Yes Hours per day? ___________ ☐ No

Do you have Medicare? ☐ Yes ☐ No If so, is Medicare your primary insurance? ☐ Yes ? ☐ No ?

☐ I plan to pay in full each visit by cash, check, or Visa/MasterCard.

☐ I am interested in prepaying for treatment.

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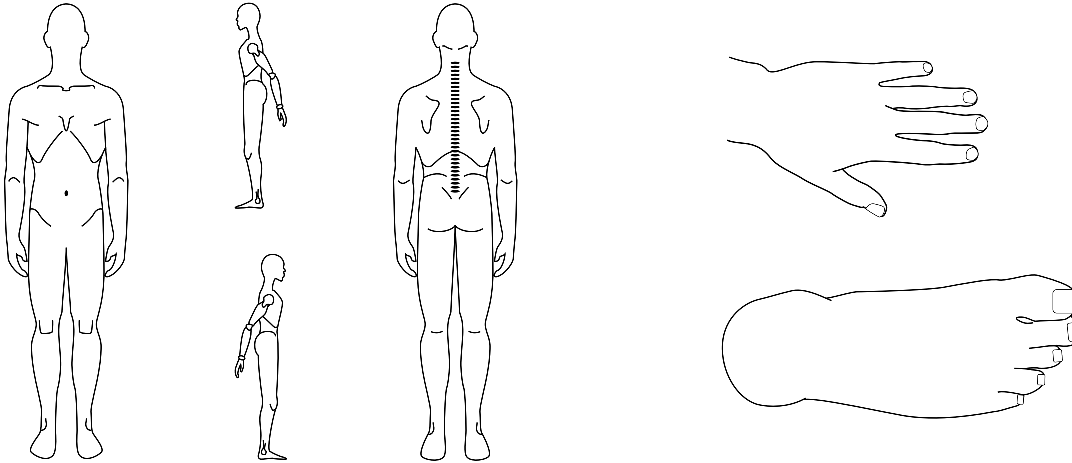
Your chief complaint: ____________________________________ **Please mark all areas of complaint:**



Check any type of medical problem you may have: ☐ NONE

☐ Headaches/Migraines	☐ Sleep Problems	☐ Fatigue	☐ Sinus/Allergy
☐ Asthma/Breathing Problems	☐ Stomach/Digestion	☐ Thyroid Issues	☐ Cancer
☐ High/Low Blood Pressure	☐ Bowel Problems	☐ Kidney/Bladder	☐ Diabetes
☐ Heart condition	☐ Stroke	☐ Carpel Tunnel	☐ Hormonal Issues

Surgeries: ____

____

Medications: (includes non-prescription): ____

Supplements/Vitamins: ____

Any known allergies (drugs, antibiotics, food, etc): ______________________

Relevant Family History: ____

Do you smoke? Please check the appropriate boxes: ☐ Never smoked ☐ Current smoker ☐ Pack(s)/ Cigarettes per day:____________

☐ Former smoker Date stopped: ___________ Number of years smoked: __________

FOR WOMEN ONLY:

Pregnant? ☐ No ☐ Yes Due Date: __________________________________

How much do you drink of the following per day (cups/8 ounces)?

☐ Coffee_________________ ☐ Water __________________ ☐ Soda __________________ ☐ Energy Drinks ____________________

☐ Alcohol _______________ ☐ Juice ___________________ ☐ Milk __________________ ☐ Tea ______________________________

What position do you sleep in the most? ☐ Back ☐ Left side ☐ Right side ☐ Stomach

Exercise: Tell us what kind and how often: ____

____

I have reviewed the information on this document and it is correct. I recognize that I am ultimately responsible for my bill. I have read, or have had read to me, the informed consent document. I have also had an opportunity to ask questions about its content, and by signing below I agree to the named procedures. 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. I also have read the HIPPA agreement. Copies of both the Informed Consent and HIPPA agree are always available upon request or from the website.

Patient Signature: ____ **Date:** ____

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Metabolic Assessment Form

Name: ____________________ Age: ______________________ Sex: ______________ Date: ___________________

Please list the 5 major health concerns in your order of importance:

1____

2____

3____

4____

5____

Please circle the appropriate number "0 - 3" on all questions below 0 as the least/never to 3 as the most/always

Category I

Feeling that bowels do not empty completely 0 1 2 3
Lower abdominal pain relief by passing stool or gas 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Diarrhea 0 1 2 3
Constipation. 0 1 2 3
Hard, dry, or small stool. 0 1 2 3
Coated tongue of "fuzzy" debris on tongue 0 1 2 3
Pass large amount of foul smelling gas 0 1 2 3
More than 3 bowel movements daily. 0 1 2 3
Use laxatives frequently 0 1 2 3

Category II

Excessive belching, burping, or bloating 0 1 2 3
Gas immediately following a meal. 0 1 2 3
Offensive breath. 0 1 2 3
Difficult bowel movements 0 1 2 3
Sense of fullness during and after meals. 0 1 2 3
Difficulty digesting fruits and vegetables;
undigested foods found in stools 0 1 2 3

Category III

Stomach pain, burning, or aching 1- 4
hours after eating. 0 1 2 3
Use antacids 0 1 2 3
Feel hungry an hour or two after eating 0 1 2 3
Heartburn when lying down or bending forward. 0 1 2 3
Temporary relief from antacids, food,
milk, carbonated beverages. 0 1 2 3
Digestive problems subside with rest and relaxation 0 1 2 3
Heartburn due to spicy foods, chocolate, citrus,
peppers, alcohol, and caffeine. 0 1 2 3

Category IV

Roughage and fiber cause constipation. 0 1 2 3
Indigestion and fullness lasts 2-4
hours after eating. 0 1 2 3
Pain, tenderness, soreness on left side. 0 1 2 3
under rib cage. 0 1 2 3
Excessive passage of gas. 0 1 2 3
Nausea and/or vomiting. 0 1 2 3
Stool undigested, foul smelling,
mucous-like, greasy, or poorly formed 0 1 2 3
Frequent urination 0 1 2 3
Increased thirst and appetite. 0 1 2 3
Difficulty losing weight 0 1 2 3

Category V

Greasy or high-fat foods cause distress. 0 1 2 3
Lower bowel gas and or bloating several hours after eating 0 1 2 3
Bitter metallic taste in mouth, especially in the morning 0 1 2 3
Unexplained itchy skin. 0 1 2 3
Yellowish cast to eyes 0 1 2 3
Stool color alternates from clay colored to normal brown;
(normal being zero and alternative being three) 0 1 2 3
Reddened skin, especially palms 0 1 2 3
Dry or flaky skin and/or hair 0 1 2 3
History of gallbladder attacks or stones 0 1 2 3
Have you had your gallbladder removed. . . . . (Y/N)

Category VI

Crave sweets during the day 0 1 2 3
Irritable if meals are missed 0 1 2 3
Depend on coffee to keep yourself going or started 0 1 2 3
Get light headed if meals are missed 0 1 2 3
Eating relieves fatigue. 0 1 2 3
Feel shaky, jittery, or have tremors. 0 1 2 3
Agitated, easily upset, nervous 0 1 2 3
Poor memory/forgetful. 0 1 2 3
Blurred vision. 0 1 2 3

Category VII

Fatigue after meals 0 1 2 3
Crave sweets during the day 0 1 2 3
Eating sweets does not relieve cravings for sugar 0 1 2 3
Must have sweets after meals. 0 1 2 3
Waist girth is equal or larger than hip girth 0 1 2 3
Frequent urination 0 1 2 3
Increased thirst and appetite. 0 1 2 3
Difficulty losing weight 0 1 2 3

Category VIII

Cannot stay asleep. 0 1 2 3
Crave salt. 0 1 2 3
Slow starter in the morning. 0 1 2 3
Afternoon fatigue 0 1 2 3
Dizziness when standing up quickly 0 1 2 3
Afternoon headaches 0 1 2 3
Headaches with exertion or stress 0 1 2 3
Weak nails. 0 1 2 3

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Category IX

Cannot fall asleep . . . 0 1 2 3
Perspire easily . . . 0 1 2 3
Under high amounts of stress . . . 0 1 2 3
Weight gain when under stress . . . 0 1 2 3
Wake up tired even after 6 or more hours of sleep . . . 0 1 2 3
Excessive perspiration or perspiration with little or no activity . . . 0 1 2 3

Category X

Tired, sluggish . . . 0 1 2 3
Feel cold – hands, feet, all over . . . 0 1 2 3
Require excessive amounts of sleep to function properly . . . 0 1 2 3
Increase in weight gain even with low-calorie diet . . . 0 1 2 3
Gain weight easily . . . 0 1 2 3
Difficult, infrequent bowel movements . . . 0 1 2 3
Depression, lack of motivation . . . 0 1 2 3
Morning headaches that wear off as the day progresses . . . 0 1 2 3
Outer third of eyebrow thins . . . 0 1 2 3
Thinning of hair on scalp, face, or genitals or excessive falling hair . . . 0 1 2 3
Dryness of skin and/or scalp . . . 0 1 2 3
Mental sluggishness . . . 0 1 2 3

Category XI

Heart palpitations . . . 0 1 2 3
Inward trembling . . . 0 1 2 3
Increased pulse even at rest . . . 0 1 2 3
Nervous and emotional . . . 0 1 2 3
Insomnia . . . 0 1 2 3
Night sweats . . . 0 1 2 3
Difficulty gaining weight . . . 0 1 2 3

Category XII

Diminished sex drive . . . 0 1 2 3
Menstrual disorders or lack of menstruation . . . 0 1 2 3
Increased ability to eat sugars without symptoms . . . 0 1 2 3

Category XIII

Increased sex drive . . . 0 1 2 3
Tolerance to sugars reduced . . . 0 1 2 3
"Splitting" type headaches . . . 0 1 2 3

Category XIV (Males only)

Urination difficulty or dribbling . . . 0 1 2 3
Frequent urination . . . 0 1 2 3
Pain inside of legs or heels . . . 0 1 2 3
Feeling of incomplete bowel evacuation . . . 0 1 2 3
Leg nervousness at night . . . 0 1 2 3

Category XV (Males only)

Decrease in libido . . . 0 1 2 3
Decrease in spontaneous morning erections . . . 0 1 2 3
Decrease in fullness of erections . . . 0 1 2 3
Difficulty in maintain morning erections . . . 0 1 2 3
Spells of mental fatigue . . . 0 1 2 3
Inability to concentrate . . . 0 1 2 3
Episodes of depression . . . 0 1 2 3
Muscle soreness . . . 0 1 2 3
Decrease in physical stamina . . . 0 1 2 3
Unexplained weight gain . . . 0 1 2 3
Increase in fat distribution around chest and hips . . . 0 1 2 3
Sweating attacks . . . 0 1 2 3
More emotional than in the past . . . 0 1 2 3

Category XVI (Menstruating Females Only)

Are you perimenopausal . . . (Y/N)
Alternating menstrual cycle lengths . . . (Y/N)
Extended menstrual cycle, greater than 32 days . . . (Y/N)
Shortened menses, less than every 24 days . . . (Y/N)
Pain and cramping during periods . . . 0 1 2 3
Scanty blood flow . . . 0 1 2 3
Heavy blood flow . . . 0 1 2 3
Breast pain and swelling during menses . . . 0 1 2 3
Pelvic pain during menses . . . 0 1 2 3
Irritable and depressed during menses . . . 0 1 2 3
Acne breakouts . . . 0 1 2 3
Facial hair growth . . . 0 1 2 3
Hair loss/thinning . . . 0 1 2 3

Category XVII (Menopausal Females Only)

How many years have you been menopausal? . . .
Since menopause, do you ever have uterine bleeding? . . . (Y/N)
Hot flashes . . . 0 1 2 3
Mental fogginess . . . 0 1 2 3
Disinterest in sex . . . 0 1 2 3
Mood swings . . . 0 1 2 3
Depression . . . 0 1 2 3
Painful intercourse . . . 0 1 2 3
Shrinking breasts . . . 0 1 2 3
Facial hair growth . . . 0 1 2 3
Acne . . . 0 1 2 3
Increased vaginal pain, dryness, or itching . . . 0 1 2 3

How many alcoholic beverages do you consume per week? ___________
How many caffeinated beverages do you consume per day? ___________
How many times do you eat out per week? ___________
How many times a week do you eat raw nuts or seeds? ___________
How many times a week do you eat fish? ___________ How many times a week do you workout? ________
List the three worst foods you eat during the average week: ___________, ___________, ___________.
List the three healthiest foods you eat during the average week: ___________, ___________, ___________.
Rate your stress levels on a scale of 1–10 during the average week: 0 1 2 3 4 5 6 7 8 9 10
Please list any medications you currently take and for what conditions: ___________

Please list any natural supplements you currently take and for what conditions: ___________

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HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.
Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.
Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, chiropractor reviews, compliance programs, audits, business planning, development, management and administrative activities.
Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.
Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you
Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.
Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.
Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.
Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.
Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.
Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.
Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.
Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.
Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.
Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.
Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.
Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.
Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Informational

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site. Your health information will not be used or disclosed without your written authorization, except as described in this notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact Andrew C Cohen, DC at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with ProActive Chiropractic or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints. The contact information for both is included below.

U.S. Department of Health and Human Services Office of the Secretary 200 Independence Avenue, S.W. Washington, D.C. 20201
Tel: (202) 619-0257 Toll Free: 1-877-696-6775 http://www.hhs.gov/contacts ProActive Chiropractic. Dr. Andrew C Cohen 22 Battery Street, Suite 505 San Francisco, CA 94111 Tel: 415-762-8141 http:/www.proactivesf.com

NOTICE OF PRIVACY PRACTICES AVAILABILITY

You will be provided a hard copy upon request at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (www.proactivesf.com) for downloading.

Informed Consent

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic xrays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic names below and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the Doctor of Chiropractic named below and/r with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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:** ______________________

Missed Appointment Policy

At ProActive Chiropractic, we respect your time and pride ourselves in our extremely short wait times, (if any). We do this by scheduling responsibly. In order for us to maintain this high quality of service, we require patients give us a 24-hour warning if they will be unable to make their appointment. If a patient does not give us this warning period, which will allow us to fill their appointment spot, it is our policy to charge for the missed appointment.

I understand the above statement and either will give a 24-hour notice if I will be unable to make my appointment or I will pay for the missed appointment.

Signature ____ **Date** ________________________________

....

Payment Agreement

Payment for the examination and treatment is required at the time of service. For your convenience, we accept cash, checks, Mastercard, and Visa. All fees are due at the time the services are rendered. If you have chiropractic insurance, we are interested in you receiving the maximum benefits. As an added service to you, our office will provide you with a superbill for you to submit to you your insurance company. However, please be advised:

1. Your insurance policy is a legal contract between you, your employer, and the insurance company. We, as healthcare providers, are NOT a party to that contract.
2. ProActive Chiropractic/Dr. Andrew Cohen is not a member of any HMO, PPO, or other provider networks. Therefore, any coverage you may have for services provided in this office will be deemed "out of network coverage" by your insurance company.
3. Many insurance companies will advise you that your coverage will be a percentage, e.g. 80% of treatment charges, usually after a yearly deductible amount has been paid by you directly to us. What is often not specified by the insurance company are plan fee schedules, annual maximums, and other limitations that will have a direct bearing on the reimbursement allowed.
4. You remain ultimately responsible for all charges incurred in this office.

Signed ____ **Date** ________________________________

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