14622 Ventura Blvd. Ste 205
Sherman Oaks, CA 91403
Tel: 818-985-5500 Fax: 845-810-5298

Welcome to Health Solutions Physical Medicine and the Los Angeles Pain Laser Center.

Our highest priority is to provide you with an integrated natural approach to finding **solutions** for your better **health**.

In order to do this we require that you fill out the paperwork to the best of your ability so we can have all of your pertinent information. This paperwork may be more voluminous than other offices you have been to in the past. This is because we strive to be more thorough than other offices and determine if and how we can help you. All information is kept strictly confidential according to HIPAA guidelines. Social Security # may be necessary for insurance or other payment purposes.

If you have health insurance you may present your insurance card to the receptionist. We may need to copy your card and driver's license so as to verify if your insurance covers any of our services, as many plans cover chiropractic, physical therapies, laboratory and diagnostic testing, X-Rays, and massage therapy.

Please answer the following questions:

1. Are you here to see if conservative, more natural methods can help your problems? Y __ N __

2. If drugs and/or surgery can be avoided is that an approach you are willing to try first? Y __ N __

3. What do you plan on gaining from your visit with our office today?

4. What gains in your overall health would you like to see in the future?

5. Please list anyone else (friends, family, co-worker) that you feel is needlessly suffering from a problem, requires medical attention, or can be healthier than they are now?

6. Do you have Medicare insurance Y __ N __

7. Are you currently:
Involved in a Worker's Compensation Y __ N __
Involved in a Personal Injury case Y __ N __

Health Questionnaire

Name: _____Age____ Home Phone #: _____ Cell Phone #: _____

Address: _____City: _____ State _____Zip: _____

Occupation: _____# Hours/Week Currently Working:_____

E-mail Address: _____Work Phone #: _____

Spouse:_____Spouse's Occupation:_____

Check off any of the following symptoms you have experienced in the past 6 months:

☐ Low Back Pain
☐ Pain between Shoulder Blades
☐ Neck Pain
☐ Tension/Headaches
☐ Fibromyalgia
☐ Tension Across Top of Shoulders
☐ Numbness/Tingling in Arms/Hands
☐ Numbness/Tingling in Legs/Feet
☐ Pain in the legs
☐ Pain in the feet
☐ Arthritis: Where: _____
☐ Tired/Fatigue
☐ Difficulty Sleeping
☐ Digestive Problems
☐ Carpal Tunnel

OTHER (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like ?(describe) _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:
☐ Moody
☐ Irritable
☐ Interrupt sleep
☐ Restricted in your daily activities

Does this affect your work:
☐ Decision making
☐ Poor attitude
☐ Decreased productivity
☐ Exhausted at the end of the day
☐ Unable to work long hours

Does this affect your life:
☐ Lose patience with spouse/children
☐ Restricted household duties
☐ Hinders ability to exercise or sports
☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

◆ Medications…Helped: Little Some Much
◆ Physical Therapy…Helped: Little Some Much
◆ Chiropractic…Helped: Little Some Much
◆ Exercise…Helped: Little Some Much
◆ Nutrition…Helped: Little Some Much
◆ Stretching…Helped: Little Some Much

OTHER _____

Insurance (Circle One): PPO HMO Not Applicable Carrier:_____

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: _____ Date: _____/_____/_____

How did you hear about us? _____

Application For Patient Care

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____ Date:_____

SS#:_____-_____-_____ Age:_____ DOB: __ __ /__ __ /__ __ Male / Female

Primary Care Physician:_____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

Occupation:_____ Employer:_____

Type of Tasks Performed/Common Movements:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name:_____ # of Children?_____ Children's Ages:_____

Emergency Contact Name:_____ Relation: _____ Phone #:_____

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Chiropractic Care? ☐ Yes ☐ No Last Visit?_____; # Visits this year?_____

Have You Ever Received Physical Therapy? ☐ Yes ☐ No Last Visit?_____; # Visits this year?_____

REFERRALS

How Did You Hear About This Office?

☐ Walk-In/Drive-By
☐ Health Lecture
☐ Gym: _____
☐ Employee/Teacher Appreciation:_____
☐ Insurance Company: _____
☐ Existing Patient: _____
☐ Radio: _____
☐ Internet: _____
☐ Ad:_____
☐ Community Event: _____
☐ Other: _____

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

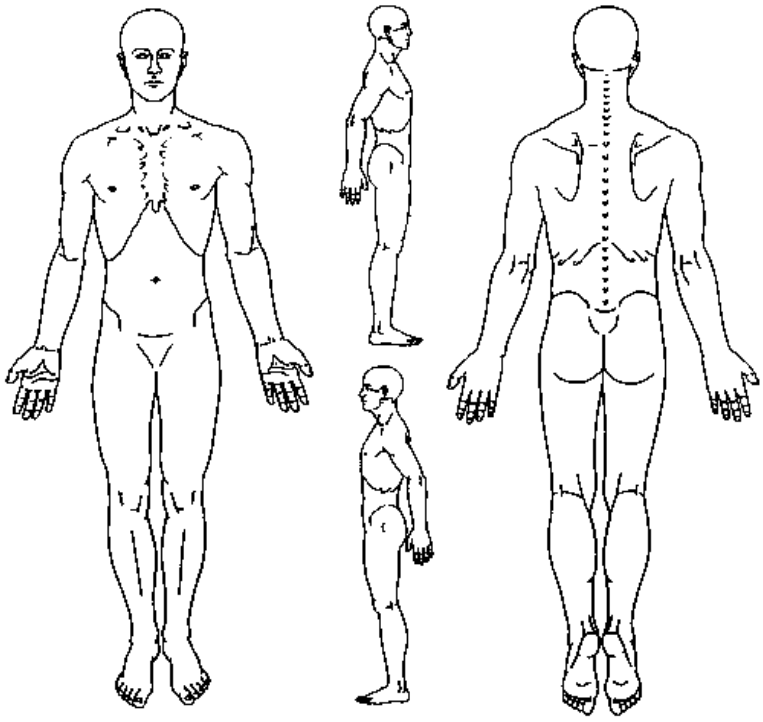
I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE*, Health Solutions Physical Medicine*, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Office Use Only: Patient Name: _____ DOB: _____

PATIENT HEALTH HISTORY

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:



- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Night Pain
- ❑ Depression
- ❑ Cold Extremities
- ❑ Nervousness
- ❑ Sleeping Difficulties
- ❑ Jaw Problems
- ❑ Loss of Smell
- ❑ Fainting
- ❑ Dizziness
- ❑ Stomach Problems
- ❑ Asthma
- ❑ Swollen Joints
- ❑ Mood Changes
- ❑ Foot Trouble
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weigh Change
- ❑ Loss of Memory
- ❑ Nausea
- ❑ Loss of Taste
- ❑ Fatigue
- ❑ Chest Pain
- ❑ Tension
- ❑ Fever
- ❑ Cold Sweats
- ❑ Constipation/Diarrhea
- ❑ Allergies
- ❑ Shortness of Breath
- ❑ Blurred/Double Vision
- ❑ Bowel/Bladder Changes
- ❑ Trouble Concentrating
- ❑ Loss of Balance

Please check if you have ever had any of the following:

- ❑ ADD/ADHD
- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bad Breath/Bad Taste
- ❑ Bleeding Disorders
- ❑ Blood Pressure: High or Low (circle)
- ❑ Breast Lump
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Colon Trouble
- ❑ Contacts/Glasses
- ❑ Diabetes
- ❑ Dry Skin
- ❑ Ear Infections
- ❑ Epilepsy
- ❑ Fractures
- ❑ Gall Bladder
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heartburn
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hormone/Gland Problems
- ❑ Insomnia
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Measles
- ❑ Menopausal Prob.
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mouth Sores or Bleeding Gums
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexual Difficulty
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tonsillitis
- ❑ Tremors
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other: _____

_____

_____

_____

Are you currently under medical care or taking prescription drugs for this problem? ❑ Yes ❑ No
If yes, explain _____

Please list any and all medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Office Use Only: Patient Name: _____ DOB: _____

ALLERGIES: (Please place a check mark next to any known allergy that you have.)

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat
___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine
___Mildew ___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects
___Dog Dander ___Cat Dander ___Latex ___Other Animal Dander ___ OTHER: _____ *(please fill in)*

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____
_____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes ____ packs/day

- **I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. will give complete and accurate information during my exam.**

SIGNATURE (X) _____ **DATE** _____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because:
_____
_____

Date of last menstrual period: _____

Office Use Only: Patient Name: _____ DOB: _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do have frequent falls or find that you trip over your feet while walking? NO YES
    Comment: _____
12. Have you tried any medications such as anti-inflammatory? NO YES
    If yes, what kind of medication?
    _____
13. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind?
    _____
14. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    _____
15. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it?
    _____
16. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment:

For any yes answer, rule in/out the diagnosis with these two tests:

A) NCU/EMG tests Upper Lower Indicated Not Indicated (circle one)
B) Vascular Test Indicated Not Indicated (circle one)

Office Use Only: Patient Name: _____ DOB: _____

Please Read: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

Office Use Only: Patient Name: _____ DOB: _____

SECTION 6 -- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

Office Use Only: Patient Name: _____ DOB: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Health Solutions Physical Medicine.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Health Solutions Physical Medicine to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Jeffrey Katlein, about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

Office Use Only: Patient Name: _____ DOB: _____

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known, or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____ _____

Patient Signature **Date**

Office Use Only: Patient Name: _____ DOB: _____

HIPAA Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

In the course of your care as a patient at Health Solutions Center, we may need to use or disclose personal and health related information about you in the following ways:

• Your personal 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 your services).

• Your name, address, email, phone number, and your health care records may be used to contact you regarding appointment reminders or other appointment related issues, to provide information about alternatives to your present care or other health related information that may be of interest to you. Periodically, thank you letters, referral cards, newsletters, birthday cards, postcards, paper clippings or email messages may be sent.

• If you are not at home to receive an appointment reminder, a message may be left on your answering machine or with another member of the household. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health insurance without your consent or authorization in the following circumstances:

• If we are providing health care services to you based on the orders of another health care provider.

• 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.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care, insurance forms 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 different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your 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 to protect the health information therein. We are also required to provide you with this notice of our privacy practices with 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 your 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.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected be the federal privacy rules.

If you have a complaint regarding our privacy notice and/or our privacy practices, or would like further information about our privacy policies and practices please contact us at the above numbers.

This notice is effective as of April 16, 2003. This notice, and any alterations or amendments made thereto, will expire seven years after the date upon which the record was created.

You will be receiving treatment in the form of chiropractic adjustments and therapies which may be performed in an "open bay" setting where other patients may observe the treatment that is being rendered to you unless you otherwise request treatment in a private location.

PLEASE READ THIS DOCUMENT CAREFULLY! PLEASE DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ IT COMPLETELY. THE PATIENT HAS FULLY READ THIS AGREEMENT AND THE SUPPLEMENT HERETO, AND HE/SHE UNDERSTANDS THEM AND AGREES TO ABIDE BY ALL.OF THE TERMS HEREOF.

_____
PATIENT NAME (PLEASE PRINT)

_____
PATIENT SIGNATURE

Date_____

_____
GUARDIAN SIGNATURE

_____
GUARDIAN NAME (PLEASE PRINT)

Date_____