Arjan K. Khalsa DC ·

Intake Form

PLEASE FILL OUT ENTIRE FORM AND WRITE CLEARLY, THANK YOU!

Your name: _____ **Legal name:** _____
Gender: M_____**F**_____ **Birthdate:** _____ **E-mail:**_____
Mailing Address (including city, state, zip): _____
Home #:_____**Cell #:**_____
Main Complaints: What brought you to our office, how long has it been going on?
1. _____
2. _____
3. _____

Minor Complaints: Are there other symptoms that we may be able to help you with?
1._____
2. _____

Major Illness in the past: Please state the type of illness and your approximate age
1. _____ 2. _____
Allergies: _____
Surgeries: _____
Prescription medicine: Please state the medication and reason for taking it.
_____ _____
_____ _____
Are there any prescription medicines that you have taken a lot of in the past? If so, which ones and for what were they used? _____
_____
Are you currently taking any herbs of supplements? How much and why?
_____

For Women:
Are you currently pregnant? _____ If yes, how long? _____ Are you nursing? _____
If there are any changes, please notify doctor immediately.
Do you have any difficulty with your monthly cycle? I.e.: cramping, back pains, fatigue, blood clots and headaches._____
_____

Family history:
Please list only the serious illnesses of you relatives. If your relative is deceased, please state the cause of death if you know it, along with the serious illness suffered while alive.
Mother: _____ Father: _____
Mother's parents: _____ Father's parents: _____
Brothers and sisters: _____ Children: _____

Stress levels:
Please use numbers to indicate stress level (1- low, 2- medium, 3- high, 4- varies)
Work ____ finances: ____ Home life ____ Primary relationship _____ Other: _____

Drug, Alcohol, and Caffeine Use:
Did you ever drink alcohol on a regular basis?_____ If so, when and how long? _____
Did you ever use non-prescription drugs? If so, which specific drugs, when and for how long a period of time?_____
Do you drink cokes or coffee? _____ if so, how much per day? _____
Do you smoke? _____ How much? _____ for how long? _____

Diet:
What have you eaten in the past 24 hours?
Breakfast _____
Lunch _____
Dinner _____
Are you interested in making changes in this area? Yes__ No__

Exercise:
Do you have any regular exercise program? Yes ____ No _____
What is it? _____
What exercise have you had in the past week?_____

Weather: (please circle one)
Does the weather seem to affect you or your symptoms? Yes/No/Sometimes/Not sure
Please explain exactly how you were affected. _____
This weather usually bothers me (yes, no, sometimes=s):
Windy ____ Cold _____ hot ____ Humid & hot ____ Damp & cold ___ Rapid changes in weather ____Change of season ____
In general, do you feel hot or cold? _____

Other: Is there anything you would like to add about your emotional or mental state or your temperament?
In the past few months, have you experienced any of these emotions more often than others? 1-often, 2-sometimes, 3-seldom
____ Anger ____ Sadness____ Grief or sorrow____ Fear____ Anxiety____ Worry

Sleep:
Do you have any problems with sleep? Yes ___ No___
Do you experience night sweats? Yes ___No___
If yes, please describe in some detail (for example, difficulty falling asleep, staying asleep, etc.)

Digestion:
Do you have any problems with digestion? Yes ___ No ____

If yes, please describe (i.e.: lack of appetite, a lot of gas, bloating, constipation, abdominal pain, etc.)

_____

Respiration:
Do you have any difficulty breathing? Yes ___ No ___
If yes, please describe in some detail (for example, I am allergic to cats, I have asthma, I get short of breath upon exertion, etc.)

_____

Elimination:
Do you have any problems with urination? Yes _____ No _____
If yes, please describe in some detail (for example, frequent urination, night urination, difficulty urinating, frequent bladder infections, etc.)

_____

Do you have difficulty with bowel movements? Yes ____ No ____
If yes, please explain (difficulty with constipation, diarrhea, both, blood or mucous in stool, etc.)

_____

Energy level:
Do you have any problems with fatigue? Yes ___ No ___ how long: _____
If yes, pleases describe in some detail (for example: tired upon waking, getting exhausted after eating or exercising, exhaustion after sexual activity, late afternoon fatigue)_____
Does anything help you? (Rest, exercise, eating less, etc.)_____

_____

Do you get headaches? Yes___ No___ If so, how often? _____

Rest and Relaxation:
What do you like to do for rest and relaxation? _____
Have you done it in the past week? _____How often do you do it? _____

Other Therapists:
Are you currently seeing any other health practitioners? Yes ____ No ____
If yes, please list them, what their specialty is and why are they treating you:

_____

_____

Is there anything else you would like to tell me that might help me serve you better?

_____

What do you think is the major cause(s) of your health problems?

_____

_____

Notice of Informed Consent

This is to verify that I have been scheduled to undergo a Chiropractic/medical evaluation to my claim of illness/injury/impairment/disability.

I understand that this evaluation is to include information about myself and my personal circumstances, as well as my health. I understand that a partial or complete physical, orthopedic, neurologic, laboratory as well as x-ray examination may be performed.

I understand that the examination is not intended to do harm or cause pain. Because of this factor, I should not perform any task beyond what I can normally and physically tolerate. I understand that it is my responsibility to make the examining physician aware of my limitations and/or hesitations.

Every type of health care is associated with some risk of a potential problem. This includes Chiropractic care. We want you to be informed about the potential problems associated with Chiropractic care before consenting to treatment. This is called an informed consent.

A subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints has moved out of its' normal alignment. This can occur through recent or remote trauma as well as unusual positions we find ourselves throughout the day or night. A subluxation has also been described as an incomplete dislocation of a joint and, as such; it is not treated with drugs or surgery. Chiropractors treat vertebral subluxations with spinal manipulation (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments. Frequently, adjustments create a "popping" sound or clicking sensation in the area being treated.

In this office we use highly trained staff to assist the doctor with portions of your consultations, examination, x-ray, physiotherapy, traction, massage, exercise instruction, etc. Occasionally, when your doctor is not available, another clinic doctor will treat you in his or her place.

Stroke: Stroke is the most serious problem associated with the spinal adjustments, regardless of whether the provider is a Chiropractor or a medical physician. A stroke occurs when a portion of the brain does not receive enough oxygen from the blood stream. The result can be temporary or permanent dysfunction of the brain does not receive enough oxygen from the blood stream.

The result can be temporary or permanent dysfunction of the brain, with a more rare complication of death. Spinal adjustments have only been associated with strokes that arise from the vertebral artery. The specific neck adjustment that is related to this complication

is never performed in this office. The most recent studies (Journal of the California Chiropractic Association Vol. 37, NO. 26-93) estimates that the incident of this type of complication occurs in 1 (one) in every 3,000,000 (three million) adjustments to the neck.

This means that the average Chiropractor would have to be in practice over 100 years before they would be statistically associated with a single patient stroke.

The most effective method of lessening the odds that a patient is prone to a stroke is through careful screening of risk factors in the history, including medications taken as well as a family history of high blood pressure and specific exam procedures to access blood flow to the brain.

Disc Herniation: Disc herniations that create pressure on nerves or the spinal cord are frequently treated successfully by Chiropractors using adjustments, distraction, and other therapies. This includes both in the neck and the low back. Yet, occasionally Chiropractic treatment will aggravate this problem. To help prevent this, patients are put through specific range of motion tests and procedures during the examination to see if any of these positions might aggravate disc symptoms. Because of such careful attention to detail, these complications occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment, traction, massage, etc. may strain some muscle or ligament fibers. The result is a temporary increase in pain requiring specific treatment for resolution, with no long-term affects to the patient.

Rib Fractures: The ribs are found attached to the thoracic spine in the middle of the back. They extend from your back to the front of the chest. Rarely, a Chiropractic adjustment may break a rib; this is referred to as a fracture. This occurs only to those who have weakened bones from such things as osteoporosis, prolonged steroid use, or other bone weakening diseases. This can be ruled out in the history or x-rays. We adjust all patients

carefully and especially those with bone weakened conditions. This problem occurs so rarely that there are no statistics to determine their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. We use different forms of heat and ice in the office and occasionally recommend them for use at home. Everyone's skin has different sensitivity to these modalities, and rarely heat or ice can irritate the skin. The result is a temporary increase of skin pain and possibly some blistering. These problems occur so rarely that there are no statistics to determine their probability.

Soreness: It is not uncommon for spinal adjustments, distraction, massage, exercise, etc. to result in a temporary increase in soreness in the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not a dangerous situation, but please do tell the doctor or a staff member about it.

Other Problem: There may be other problems or complications that may arise from Chiropractic treatment other than those mentioned above. These other complications occur so rarely that it is impossible to anticipate or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any healthcare delivery system, we cannot promise a cure for all symptoms, diseases, or conditions as a result of treatment at this facility. We will always give you the best care that we can deliver and if the results are not acceptable, we will gladly discuss other types of treatment options or refer you to another health care provider for alternative types of treatment.

If you have any questions on the above information, please ask doctor to explain them more fully. When you have a full understanding of this material, please sign and date this document below and then return it to the front desk or the doctor.

_____ _____

Patient signature Date

_____ _____

Patient Name (Please Print) Date

_____ _____

Witness Date

Arjan Khalsa
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Privacy Practices

I consent to the use or disclosure of my protected health information by Dr. Khalsa for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Khalsa.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Khalsa is not required to agree to the restrictions that I may request. However, if Dr. Khalsa agrees to any restriction that I request, the restriction is binding on Dr. Khalsa .

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Narayan Chiropractic.

This Notice of Privacy Practices also describes my rights and Narayan Chiropractic duties with respect to my protected health information.

Narayan Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a Revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Narayan Chiropractic are not in a legal partnership and this document is condensed simply to save paper and time.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Policies:

____ (Initials) **Missed appointments**: **We ask that you give the Center at least one business day's notice to cancel or reschedule an appointment. *You will be charged $35.00 if no notice is given.* After three or more missed appointments within a calendar year, we reserve the right to refer your care to another provider. Exceptions will be made for emergencies.**

I acknowledge that I have read and understand the above information.

Signature_____Date:_____

Parent/Guardian:

_____Date:_____