We Listen… We Care…
We Get Results!

Peak Performance Chiropractic
Dr. Steven B. Hansen D.C.
8580 Elk Ridge Way, Ste. B
Elk Grove, CA 95624

Personal Information

Your Health Profile

Name: Patient #: Age: Date:

Address: Social Security #

City / State / Zip:

Home Phone: Work Phone: Cell Phone:

E-Mail Address: Male Female

Birth Date: Best Time & No. To Contact:

Occupation: Employers Name:

Single: Married: Divorced: Widowed: Employer Address:

Number of Children: Names, Ages and Gender:

Who may we thank for referring you to our office?

Your Health Profile

Why This Form Is Important

As a Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.

Addressing what brought you to this office.
If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History." (next page)
Others, please briefly describe your chief concern, including the effect it has had on your life.

Health Concerns: List health concerns according to their severity	Rate of Severity 1= mild 10= worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with and injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					

If you are experiencing pain, is it……

☐ Sharp ☐ Dull ache

Does the pain travel/radiate anywhere: ☐ NO ☐ YES – please describe

Since the problem started, it is …. ☐ About the same ☐ Getting Better ☐ Getting Worse

What makes it worse?

What have you done for this condition that has helped you feel better? _____

What have you done for this condition that was of no help? _____

☐ I do ☐ do not have a family history of this or similar symptoms (if you do, please explain)

Is this condition interfering with your: ☐ Work ☐ Leisure ☐ Sleep ☐ Sports/exercise/walking

☐ Positive mental attitude ☐ Hobbies ☐ Other _____

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what?

Other Doctors seen for this condition: ☐ Chiropractor ☐ Medical Dr. ☐ Other

1. Name/Address: _____

   Date: _____ What was the diagnosis? _____

   What was done? _____

2. Name/Address: _____

   Date: _____ What was the diagnosis? _____

   What was done? _____

General History:

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Urinary Problems	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking and why: (**prescription** and **non-prescription**) _____

Have you had any surgery? (please include all surgery)

1. Type _____ Date: _____ Doctor: _____
2. Type _____ Date: _____ Doctor: _____
3. Type _____ Date: _____ Doctor: _____
4. Type _____ Date: _____ Doctor: _____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1.Type _____ Date: _____ Hospitalized ☐ Yes ☐ No

2. Type _____ Date: _____ Hospitalized ☐ Yes ☐ No

3. Type _____ Date: _____ Hospitalized ☐ Yes ☐ No

Have you ever had x-rays taken? (if yes) When _____ Where _____

Area of body: _____

Do you wear orthotics or heel lifts? ☐ Yes ☐ No

Please list your top three stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.)
   a. _____
   b. _____
   c. _____
3. Psychological stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

The Beginning Years

Research is showing that many of the health challenges that occur later in life originated during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Birth to 17 years of age	Yes	No	Unsure
Did you have any serious childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs (prescribed or not)?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Were you involved in any car accidents?	☐	☐	☐
Was there any prolong use of medication such as, antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
Were you under regular chiropractic care?	☐	☐	☐

Comments: _____

Adult- (18 to present)

	Yes	No
Do/did you smoke?	☐	☐
Do/did you drink alcohol (more than socially)?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐
Do you play any adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1-10 describe your psychological/emotional stress levels: (1= none / 10= extreme)

Occupational: _____

Personal : _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits: _____ Exercise habits: _____ Sleep: _____

General Health: _____ Mind-set: _____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list below their names and any health conditions or concerns they may have:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Others: _____

Have you ever:

Bought bottled water:	☐ Yes	☐ No
Belonged to a health club:	☐ Yes	☐ No
Consumed vitamins of supplements:	☐ Yes	☐ No
If there is a need for dietary changes or nutrients would you like to be informed?	☐ Yes	☐ No
It there is a need for specific exercises would you like to be informed?	☐ Yes	☐ No
If there is a need for support in the psychological/mind/body/stress dimension of health would you like to be informed?	☐ Yes	☐ No

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature _____ **Date:** _____

Thank you for filling out this form. It is your first step to **Creating Wellness!**

Return this to our staff and someone will be right with you.

DR. STEVEN HANSEN, DC
8580 Elk Ridge Way Ste B
Elk Grove, Ca 95624
916-685-1230

INFORMED CONSENT, CHIROPRACTIC CARE WITH DR. HANSEN

Every type health care delivery system has some associated risks and the potential for occasional problems of some kind. Humans and their injuries are unique, and something that might be effective for one person might not be helpful to another. We are committed to providing you with the best and safest care possible however; we have a responsibility to you to inform you about some of the problems that are rarely or occasionally associated with chiropractic treatment. Before you start your treatment, you must review this notice and consent to receive chiropractic care**.** ***This is called informed consent.*** Please feel free to discuss directly with
Dr. Hansen any questions or concerns that you may have.

Disc Herniation: Disc herniations are frequently and successfully treated by chiropractors. Occasionally, chiropractic treatment may aggravate the problem, and rarely surgical intervention may become necessary if the chiropractic care is not successful. Vary rarely, chiropractic adjustments may also cause a disc problem if the disc is already damaged or in a weakened condition. These problems occur so rarely that there is no available statistical information to quantify their probability.
Soft Tissue Injury: Soft tissues primarily refer to muscles, tendons, and ligaments. Rarely, a chiropractic adjustment, traction, massage, etc. may overstretch or tear some muscle, tendon, or ligament fibers. The result is a temporary increase in pain and a brief, temporary increased need for treatment, but in most every case there are no long-term effects to the patient. These problems occur so infrequently and are so rare that there are no available statistics to quantify their probability.
Rib Fracture: Rarely, chiropractic adjustment(s) may crack a rib bone. This risk is increased in elderly, osteoporotic bones. We adjust all patients very carefully, especially our elderly patients with osteoporosis. These problems of rib fracture occur so rarely that there are no available statistics to quantify their probability.
Burns: Some of the physiotherapy equipment generates heat (diathermy, ultrasound) and we also use ice and hot packs. Rarely, these modalities- ice or heat- can irritate or cause superficial skin burns. This can result in a temporary increase in localized pain, reddening, swelling, or in some rare cases, blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.
Soreness: Chiropractic adjustments, traction, massage therapy, exercise, etc. may result in temporary increase in soreness. This is usually a very temporary symptom. It is not dangerous, but please tell your doctor about it.
Stroke: Stroke is VERY uncommon, but it is the most serious problem associated with vertebral manipulation of the cervical spine (neck). In the May, 1994 Chiropractic Report, they discuss this problem, **"By any medical standard, chiropractic cervical adjustment is an extremely safe treatment. Vertebral artery injury causing stroke is the only serious potential complication. There is a risk rate (incidence) of about .0002%, or one case in two million." In another study, (Journal of CCA, Vol. 37, No. 2, June 1993) they estimate that the risk of this type of stroke is .0003%, one in three million.**

Other Problems: There may be other problems or complications that might arise from chiropractic treatment, other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate, predict, or explain them all in advance of treatment. Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system, we cannot promise or guarantee to cure any symptom, disease, or condition. Please keep your doctor advised of **any** situation that occurs, since early identification is important to minimize side effects and to provide you with the best care that you deserve. Finally, if you have questions regarding any of the above information or concepts, please ask your doctor. When you have a full and satisfactory understanding, please sign and date below.

_____ _____

PATIENT SIGNATURE **DATE**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name: _____

Date of Birth: _____ SSN# : _____

I hereby instruct and direct _____ Insurance Company
To pay by check, made out and mailed directly to:

Steven, B. Hansen, D.C.
8580 Elk Ridge Way, Suite B
Elk Grove, CA 95624

If my current policy prohibits direct payment to Dr. Steven B Hansen, then I hereby also instruct and direct you, to make out the check to myself, and mail it as follows:

Steven, B. Hansen, D.C.
8580 Elk Ridge Way, Suite B
Elk Grove, CA 95624

The professional of medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorized the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ _____ _____
Signature of Policyholder Signature of Claimant, if other than policy holder Date

***** By signing above, the deductible and co-payments of my chiropractic treatments would be a financial hardship on me *****

LETTER OF NO ACCIDENT OR WORK IN JURY
Steven B. Hansen, D.C.

Patient's Name

Dear Insurance Company,

This letter is to inform you that I was not involved in any auto or work related injury for this diagnostic test and/or treatment.

Please note the following:

_____ I state that I was not involved in any auto accident or personal injury
(Initial) caused by any other party. I further state that my diagnostic test or treatment is not the result of an injury while on the job or by any other person related to my employment.

Please process my claim with no delay!!

Sincerely,

Patient's Signature Date

Steven B Hansen D.C.
8580 Elk Ridge Way, Suite B
Elk Grove, CA 95624

Personal Medical Information Consent Form
HIPPA

The Health Insurance Portability Accountability Act of 1996 (HIPPA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations, of our practice.

HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desired, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing t his consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

_____ _____

Patient Signature Date

RESTRICTIONS:

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practice. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Steven B. Hansen, D.C. & Staff