Bienvenidos!

Por favor tomen unos minutos para completar el cuestionario. Si tiene alguna pregunta les podimos ayudar. Estamos contentos de podar ayudartes con su salud.

Informacion de Paciente

Nombre: _____ Seguro Social: _____
Apeido Primer Nombre Inicial

Direccion: _____

Ciudad: _____ Estado: _____ Codigo Postal: _____
Numero de Telefono : _____ Celular: _____
Correo Electronico : _____
Sexo ☐ M ☐ F Edad _____ Fecha de Nacimiento : _____
☐ Soltero ☐ Casado ☐ Divorciado ☐ Viuda ☐ Sparado
Nombre de Epleador _____ Ocupacion _____
Domicilio de Trabajo _____
Numero deTelefono de Emlpleo _____ Correo Electronico _____
Persona notificada encaso de emergencia _____
Numero de Telefono _____ Numero de Trabajo _____
Celular _____ Correo Electronico _____
A quien le daremos graciouss por referielo _____

Rason Por La Visita

A vista un quiropractico antes? ☐ Si ☐ No Por que rason _____
Su rason por la vista _____
Porfavor describa su dolor y su locasion _____
Cuando empesaron sus sintomas (fecha)? _____ A tenido condiciones similares en el pasado?
_____
El doloe esta poniendo: ☐ Peor ☐ Mejor ☐ Igual ☐ Va y Viene
Que tan frecuente tiene el dolor? _____
En donde y cuando? _____
Se a tratado con un doctor de estas condicioned? _____
Cuando y donde _____
Actividades o movimientos que estan dificiles para hacer ☐ Sentandose ☐ Caminando ☐ Agachandose ☐ Levantando
Tipo de Dolor: ☐ Fuerte ☐ Pequeno ☐ Doloroso ☐ Camason ☐ Dolor ☐ Matizar ☐ Intumasion ☐ Colico ☐ Rigidez ☐ Inflamasion
El Dolor interfiere con: ☐ Trabajo ☐ Al Dormir ☐ Durante el Dia ☐ Recriacion

Historial De Salud

Escriba medicasion que esta tomando (incluiendo mdicina para dolor) _____
_____
Porfavor escriba cualquier acidente o cirugia que a tenido en los ultimos 10 anos :
Caidas _____ Fecha _____
Accidente en cabeza _____ Fecha _____
Huesos _____ Fecha _____
Deslocasiones _____ Fecha _____
Cirugias _____ Fecha _____
Otros accidentes graves _____ Fecha _____
Mujeres : Esta embarasada ☐ Si ☐ No Cuantos meses : _____

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures including examination, diagnostic x-rays and physical therapy techniques, on me (of on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licenses doctors of Chiropractic who now, or in the future, render treatment to me while employed by, working for, or associated with, or serving as back up for the doctor of Chiropractic named below.

I understand that as with any health care procedures, there are certain complications which may arise during Chiropractic adjustment. Those complications include, but are not limited to; fractures, disk injuries or dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then, known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the natural purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the Chiropractic adjustments and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Name(s) of Doctor(s) Treating Patient:

James Baranski, D.C.
Ventura Spine & Sport Chiropractic
4601 Telephone Rd., Suite 110
Ventura, CA 93003
(805) 642-4061

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Patient Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay _____ as well as all employees, employers, representatives, and agents thereof, (collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, test, and/or medications that *have been* or *will* be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any heath status, conditions, symptoms, or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoke in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____20_____ .

_____

(Patients signature)

_____

(Please print patient name)

_____

(Signature of Guardian if Applicable)

Privacy Practices Acknowledgement

I have been given the opportunity to review the Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide Advanced Spine & Sport Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

_____

Printed Name of Patient

_____ _____

Patient Signature Date

Medical Release of Information to PCP/Ortho

It is our intention to communicate with your primary care physician or other providers providing you service for your medical conditions from time to time to keep them posted on your care being provided in our office. This is an effort to maintain the highest quality of care for you and your family.

I hereby authorize the provider to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. Should you not want us to communicate with them please indicate by checking the appropriate box below.

[ ] We are welcome to communicate with my PCP and other healthcare providers taking care of me.
[ ] I would prefer you not to communicate with my PCP and other health care providers that take care of me.

I, _____ have read and fully understand the above statements.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Physician Names

1. _____
2. _____
3. _____

(EVALUASION/DOLOR DEL PASIENTE)

Patient Pain/Function Evaluation Form

(NOMBRE)
PATIENT NAME: _____

(FECHA)
DATE: _____

Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

(DOLOR ACTUAL)
- Current pain: ___/10 0 1 2 3 4 5 6 7 8 9 10

(DOLOR PROMEDIO)
- Average pain: ___/10 0 1 2 3 4 5 6 7 8 9 10

PAIN LEVEL DURING:

(ACTIVIDADES de la vida DIARIA)
- Activities of Daily Living: ___/10 0 1 2 3 4 5 6 7 8 9 10

(TRABAJO)
- Work: ___/10 0 1 2 3 4 5 6 7 8 9 10

(DEPORTES)
- Sports/Recreation: ___/10 0 1 2 3 4 5 6 7 8 9 10

Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

- ☐ Aching/DOLOR
- ☐ Burning/ARDIENTE
- ☐ Cramps/CALAMBRES
- ☐ Dull/DOLOR Sordo (Leve)
- ☐ Numbness/ENTUME
- ☐ Sharp/AGUDO
- ☐ Shooting/DOLOR INSORPORTABLE
- ☐ Stabbing/Puñalada
- ☐ Stiffness/RIGIDEZ
- ☐ Swelling/INCHADO
- ☐ Throbbing/PUNZANTE
- ☐ Tingling/HORMIGAS
- ☐ Other, describe it: OTRO? DESCRIBA? _____

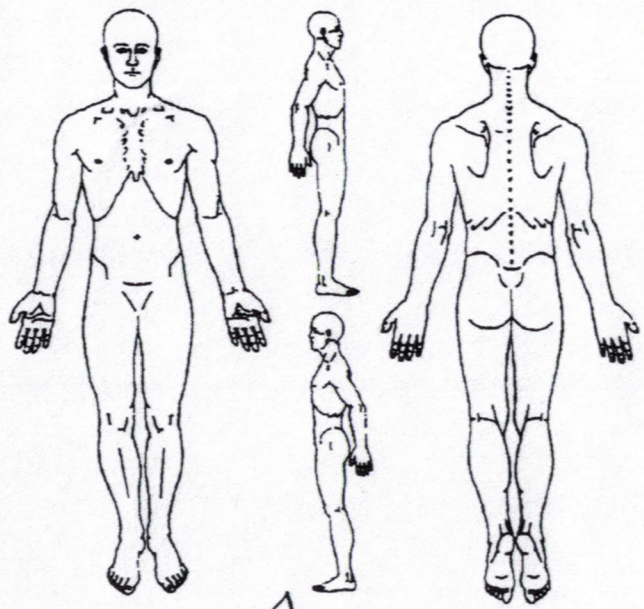
Activities or movements that are painful to perform: Actividades oh MOVIMIENTOS QUE SON DIFFICIL?

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ None ☐ Other _____
Sentado Parado Caminar Agachado Acostado NADA OTRO?

When and what makes it better? _____
QUE LO HACE SENTIR MEJOR?

When and what makes it worse? QUE LO HACE SENTIR PEOR?

Please mark on the diagram the location of the pain.



POR FAVOR MARQUE EN DONDE EXSATAMENTE EL DOLOR.

Esta dando pecho ? ☐ Si ☐ No

Condiciones Medicales

A tenido o tiene condiciones de la siguiente ?

☐ Hepatitis ☐ Hechar ☐ Anemia ☐ Artritis ☐ Mareos ☐ Cancer ☐ Gota
☐ Sida o HIV ☐ Ulseras/ Colitis ☐ Dolor de Quijada ☐ Dolor en Mano
☐ Dificultar al Respirar ☐ Dolor escueso (Frecuentemente)
☐ Dolor en el Hombro ☐ Dolor en la Piernals ☐ Problems de Espalda
☐ Ataque al Corazon / Embolio ☐ Congestionales del Corazon
☐ Abuse de Drogas o Alcohol ☐ Des mallos, Mareos, Epilepsia
☐ Dolor fuerte de Loido ☐ Sumbido en los Loidos ☐ Diabetis/ Tuberculosis
☐ Glaucoma / Emphysema ☐ Problemas de Riñon
☐ Dolor de Cabeza Fuerte (frecuentemente) ☐ Huesos o Conyuntura Artifisial
☐ Intumido, Donde ?_____
☐ Mantizar, Donde ?_____
☐ Espasmo de musculo, Donde ?_____

Habitos Personales

	Mucho	Mediano	Ligero	Ninguno
Alcohol	☐	☐	☐	☐
Cafe	☐	☐	☐	☐
Tabaco	☐	☐	☐	☐
Drogas	☐	☐	☐	☐
Exercisio	☐	☐	☐	☐
Dormir	☐	☐	☐	☐
Apetito	☐	☐	☐	☐

Authorization

He leido la informacion del questionario y e respondido lo mas que o podido. Entrendo que esta infomacion estaria us do por el quirpractico para deteminar el tratamiento apropiado. Si hay algun cambio en mi status le informare al quiropractico.

Yo autorizo a mi aseguranca para que page al quiropractico y gropo quiropractico los beneficios, distinto pagadero a mi por servicios denretiros. Yo autorizo esta firma a todas asegurancas sumision.

Yo autorizo que el quiropractico de liberar la informacion necesaria para asegurar el pago o benefisios. Yo entiendo que soy responable de pago de page la aseguranza o no.

Firma_____ **Fecha**_____