Precision Chiropractic

CONFIDENTIAL HEALTH QUESTIONAIRE Date: ________________________

Name: ___________________________________ Address: ____

City, State, Zip: _______________________________________ Home Phone: _________________________

Cell Phone: ____________________ Work: ____________________ Email: ___________________________

Would you like text and/or email appointment reminders? ☐ text (2 hours prior) ☐ email (1 day prior)

*cell phone provider:____________________

SS #: ________________________ Birth Date: _________________ Age: __________ ☐ Male ☐ Female

# of Children: _______ ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name: ________________

Occupation: ____________________ Employed By: ______________ Cell or Work #: ___________________

Work Address: ____________________________ City, State Zip: ____________________________________

Whom may we thank for referring you to us? ____

Which doctor were you referred to: ☐ Dr. Tomp ☐ Dr. Hoefer

Have you ever had Chiropractic Care before? If yes, when? ☐ No ☐ Yes When: ____________________

List your chief complaints in order of severity:

1) ____ For how long? __________________________________

2) ____ For how long? __________________________________

3) ____ For how long? __________________________________

List Doctors consulted for this condition:

1) _____________________________________ Address/Phone(optional): ______________________________

2) _____________________________________ Address/Phone(optional): ______________________________

Is this injury/illness work related? _____________ Have you reported it to your employer? ________________

Is this injury/illness related to an automobile accident? __________ *If yes, please ask front desk for an auto accident questionnaire.*

Do you have health insurance? __________ Company Name: ____

(Please let the front desk have a copy of your insurance card.)

Are you covered under any other health insurance plan? _______________________

Spouse's Social Security # (optional): ____________________ Employer ______________________________

Address: __________________________________ City, State, Zip ____________________________________

Notice: Not all patients require x-rays to determine or verify a diagnosis, type of treatment and length of treatment. If your examination warrants x-ray analysis, the following office policy prevails:

1) All first visit charges are payable when services are rendered.
2) The fees paid for treatment of x-rays are for analysis only. The film itself is the property of this office.

Patient Signature: ____ Date: _________________________

Precision Chiropractic

ASSIGNMENT OF BENEFITS

I hereby assign payment to Alfred W. Tomp, D.C., Elizabeth S. Hoefer, D.C. or Tomp Chiropractic Corporation, any and all benefits payable by my insurance or health plan (s) as a result of charges incurred by me for services rendered by Tomp Chiropractic Corporation at the below address. I understand and agree to pay such expense not paid by this assignment. I agree that in the event I receive a check, draft or payment subject to this agreement, such monies shall be held in trust for Tomp Chiropractic Corporation I will immediately deliver said check or draft or payment to Tomp Chiropractic Corporation. I also give this office power of attorney to endorse checks made out to me, to be credited to my account for services rendered. I also agree that a photocopy of this assignment shall serve in lieu of the original.

Patient Name (print clearly): ____

Patient Signature: ____________________________ Date: ______________________

Insured Name (if different):____

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.

In the course of your care as a patient at Precision Chiropractic we may use or disclose personal and health related information about you in the following ways;

- Your protected 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, agent, adjuster, HMO, PPO, or your employer, if they maybe responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used by our office only to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the notice to this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that maybe of interest to you. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- 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 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.

You have the right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care 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 specific form please advise us in writing. You have the right to inspect and/or copy your health information 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 the health protected 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 our 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 your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: If you would like further information about our privacy policies and practices please contact: You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services.

If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

Please list other people (*i.e. spouse, child, friend, personal trainer, attorney, massage therapist, acupuncturist, nutritionist)* with whom you authorize Precision Chiropractic to discuss your chiropractic care and health information. You may remove or add names to this at any time in writing.

Full Name (leave blank, add, or remove names at any time)	**Relation to you**

This notice is effective as of April 2003, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed) ______________ Signature ______________ Date ______________

If you are a minor, or if you are being represented by another party

Personal Representative (Printed) ______________ Personal Representative Signature ______________ Date ______________

Precision Chiropractic

30372 Esperanza, Rancho Santa Margarita, CA 92688

949.589.9962

Name: ____ Date: ________________

Medical Outcomes Study: 36- Item Short Form Survey Instrument

1. In general, would you say your health is:

   Excellent Very good Good Fair Poor

2. **Compared to one year ago**, how would you rate your health in general **now**?

   ○ Much better now than one year ago

   ○ Somewhat better now than one year ago

   ○ About the same

   ○ Somewhat worse now than one year ago

   ○ Much worse now than one year ago

The following items are activities you might do during a typical day. Does **your health now limit you** in these activities?

If so, how much? **Check One Box for Each Line**

	Limited a lot	Limited a little	Not limited at all
3. **Vigorous activities**, such as running, lifting heavy objects participation in strenuous sports			
4. **Moderate activities**, such as moving a table, pushing a vacuum, bowling or playing golf			
5. Lifting or carrying groceries			
6. Climbing **several** flights of stairs			
7. Climbing **one** flight of stairs			
8. Bending, kneeling or stooping			
9. Walking **more than a mile**			
10. Walking **several blocks**			
11. Walking **one block**			
12. Bathing or dressing yourself			

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

13. Cut down the amount of time you spend on work or other activities Yes No
14. Accomplished less than you would like Yes No
15. Were limited in the kind of work or other activities Yes No
16. Had difficulty performing the work or other activities (took extra effort) Yes No

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

17. Cut down the **amount of time** you spent on work or other activities Yes No
18. **Accomplished less** than you would like Yes No
19. Didn’t do work or other activities as **carefully** as usual Yes No

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all Slightly Moderately Quite a bit Extremely

21. How much **bodily** pain have you had during the past 4 weeks?

Not at all Slightly Moderately Quite a bit Extremely

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside and home and housework)?

Not at all Slightly Moderately Quite a bit Extremely

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**…

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep?						
24. Have you been a very nervous person?						
25. Have you felt so down in the dumps that nothing could cheer you up?						
26. Have you felt calm and peaceful?						
27. Did you have a lot of energy?						
28. Have you felt downhearted and blue?						
29. Did you feel worn out?						
30. Have you been a happy person?						
31. Did you feel tired?						

32. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time Most of the time Some of the time A little of the time None of the time

How **TRUE** or **FALSE** is each of the following statements for you. **Circle One**

33. I seem to get sick a little easier than other people

Definitely True Mostly True Don't know Mostly False Definitely False

34. I am as healthy as anybody I know

Definitely True Mostly True Don't know Mostly False Definitely False

35. I expect my health to get worse

Definitely True Mostly True Don't know Mostly False Definitely False

36. My health is excellent

Definitely True Mostly True Don't know Mostly False Definitely False