



Acknowledgement of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice has been received.

Therefore, I, _____ (printed name of patient or personal representative), acknowledge that HEAL BY HAND WELLNESS CENTER (Michelle Leach Chiropractic Corporation) has provided a written copy of its Notice of Privacy Practices for Protected Health Information to me or to the personal representative of this patient. (If signing as a personal representative, documentation of your legal right to do so must be provided.)

Signature of Patient/Patient Representative

Date

Printed Name

Relationship to Patient (if not self)

To be completed by Michelle Leach Chiropractic

We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

Signature

Date

Printed Name

Title

Confidential Case History

Thank you for choosing our practice for your health care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Patient Information

Name _____ Date _____
Address _____ City _____ State ____ Zip _____
Home phone _____ Cell phone _____ Work phone _____
Where do you prefer to receive calls? _____ Email address _____
Sex: M / F Age _____ Birthdate _____ Height _____ Weight _____
Marital Status: Single / Married / Domestic Partner / Separated / Divorced / Widowed
Employer/School _____ Occupation _____
Employer/School Address _____ City _____ State ____ Zip _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone _____
Have you received chiropractic before? _____ When/where? _____
Have you received acupuncture before? _____ When/where? _____
Have you received massage or energy therapy before? _____ When/where? _____

Symptoms

What is the main problem for which you are seeking treatment?

Rate the severity of your pain (1: mild pain or discomfort, to 10: severe pain): 1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramping Stiffness Swelling Other _____

When did you first notice the symptoms? _____

Where specifically is the problem(s) located? _____

Is the pain constant or does it come and go? _____

Does anything make your condition better? (i.e. rest, heat, ice, etc.) _____

Does anything make your condition worse? _____

Is there any time of day in which your condition is worse? _____

Is this condition getting progressively worse than when it began? _____

Which activities are difficult to perform?

Sitting Standing Walking Bending Lying down Other _____

What other forms of treatment have you already received for your condition?

Medication Surgery Physical Therapy Other _____

Name and address of other doctor(s) who have treated you for your condition:

Medical History

Please indicate any significant condition that you have experienced in the past 6 months.

General

- Alcoholism
- Substance abuse
- Insomnia
- Dreams/nightmares
- Fatigue
- Poor memory
- Recent weight loss/gain
- Chills
- Fever
- Anorexia
- Bulimia
- Irritability
- Depression
- Mood swings
- Anxiety
- Emotional disorder
- Suicide attempt
- Psychiatric care

Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

Eyes

- Glasses/contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters

- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

Nose, Throat & Mouth

- Sinus infection
- Hay fever/ allergies
- Allergy shots
- Frequent sore throat
- Difficulty swallowing
- Tonsillitis
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Nasal congestion
- Loss of voice
- Excessive thirst
- TMJ
- Gum problems
- Dry mouth

Skin

- Hives
- Rashes
- Ulcers
- Eczema/psoriasis
- Night sweats/excess sweat
- Dry skin
- Easy bruising
- Changes in moles/lumps
- Itching

Respiratory

- Difficulty breathing
- Wheezing/asthma
- Chronic cough
- Bronchitis
- Coughing up phlegm
- Coughing up blood
- Shortness of breath

- Tight chest
- Cold hands and feet
- Emphysema
- Pneumonia
- Whooping cough

Cardiovascular

- High blood pressure
- Low blood pressure
- High cholesterol
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- History of blood clots
- Hemophilia
- Anemia
- History of heart attack
- Heart Disease
- Pacemaker

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall bladder disorder

- Fissures
- Liver Disease
- Appendicitis
- Hernia

Musculoskeletal

- Rheumatoid Arthritis
- Osteoarthritis
- Joint pain
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Plantar Fasciitis
- Herniated disc
- Osteoporosis
- Fractures
- Metal pins
- Prosthetic device

Neurological

- Seizures
- Tremors
- Numbness or tingling

- Pain
- Pinched nerve
- Paralysis
- Poor coordination
- Multiple Sclerosis
- Parkinson's disease

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles
- Kidney disease
- Prostate problems

Infection Screening

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk
- Vaginal infections
- Venereal disease: _____
- Genital warts
- Herpes: oral/genital

Other

- Cancer
- Tumors, growths
- Breast lump
- Stroke
- Diabetes
- Gout
- Thyroid disease
- Goiter
- Mononucleosis
- Chicken pox
- Measles
- Mumps
- Polio
- Rheumatic fever
- Scarlet fever
- Typhoid fever

Please list any other problems or disorders you have experienced: _____

Dates of last exams: _____

List any vaccinations you have recently received: _____

List any accidents, surgeries or hospitalizations and the dates which they occurred:

Do you take any blood thinners? (Coumadin, Warfarin, Heparin) _____

Please list all medications you are currently taking (prescription and over-the-counter) and the condition associated with them: _____

List any allergies that you have: _____

Women—Pregnancy and Gynecology

Date of last menstrual period _____ # of days period typically lasts _____

Are you pregnant? Yes No If yes, how many months? _____

Nursing? Yes No Taking birth control pills? Yes No

Do you take oral contraceptives? _____ # of pregnancies _____ # of live births _____

of miscarriages _____ Age of menopause _____ Hormone replacement therapy? _____

Do you experience the following conditions? Heavy flow Scanty flow Spotting (mid-cycle) PMS
 Painful menses Clots Vaginal discharge Uterine prolapse Uterine Fibroids PCOS

Daily Habits

What do your daily work habits include? (ex sitting, standing, light labor, heavy labor, computer work)

What type of exercise do you perform? _____ How often _____

What non-work activities do you do enjoy doing? _____

What vitamins and herbs do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Dietary restrictions/food sensitivities _____

Food cravings _____

Diet: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you smoke? Yes No How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Do you use recreational drugs? What/how often? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date



Michelle Leach Chiropractic Corp.
HEAL BY HAND WELLNESS CENTER
9474 Kearny Villa Road, #113
San Diego, CA 92126



Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short-term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
- b) There are reported cases of stroke associate with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
- c) There are reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications or procedures given for the same symptoms.

I acknowledge that I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Name (print)

Patient Signature (or Legal Guardian)

Date



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Physical Therapy Treatment Agreement and Release of Liability

Welcome to Michelle Leach Chiropractic Corporation! We are excited to know that you have chosen our wellness center for your physical therapy needs. Our therapists are licensed and/or certified, professional, and respectful of our clients needs. Male/female genitalia and women's breasts will not be exposed or massaged at any time. Draping will be used during the session. Should you have any questions, comments, or complaints about your Physical Therapist, please bring it to the attention of the management immediately.

It is your responsibility to inform the therapist of any pre-existing conditions, limitations or specific sensitivities and inform your therapist if you feel any discomfort during the session. If you do experience discomfort, please ask your therapist to adjust the level of pressure. You understand and voluntarily accept any risks of which you have been advised associated with your massage, or form of any use of MLCC facility, and hereby release MLCC (including its employees, practitioners, agents and insurers) from all liability for any injury, including, without limitation, personal, bodily or mental injury, economic loss or any damage to you resulting there from. You further hereby release all of the foregoing personnel and entities from all liability arising from any such injury or damage resulting from your failure to disclose and pre-existing condition, limitation or specific sensitivities, or your failure to inform your therapist of any discomfort during the session due to health related concerns. In this event, you may be required to provide MLCC with a physician's medical release prior to continuing treatment. The undersigned acknowledges that he/she has read this agreement.

Have you received massage or energy therapy before? _____

When was your last session? _____

Desired Pressure: Light Firm Deep

What do you prefer? Lotion Oil Both

Patient Signature (or Legal Guardian)

Date



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Acupuncture Consent to Treatment

I, _____, voluntarily consent to receive Acupuncture and Chinese Herbal Medicine treatment administered by Carla Nerelli, L. Ac., who is certified by the State of California to practice Acupuncture and Chinese Herbology. I understand her training is in Acupuncture and Oriental Medicine and that she is not, nor claims to be, a medical doctor.

I understand that the evaluation given to me is an energetic assessment of the functioning of any organs and the Qi moving in the Acupuncture Meridian Network; it in no way purports to be, or replaces allopathic (Western) medical evaluation, diagnosis or treatment.

I have provided a full history and description of complaints, which is complete and accurate. I understand that the need for communication with all of my health care providers regarding my health status is ongoing and necessary. I understand that no guarantee has been made concerning the use and effects of Acupuncture and Chinese Herbal Medicine. I understand that I may stop treatments at any time.

I understand that Acupuncture is the insertion of fine sterile needles, with or without the addition of electrical stimulation, through the skin, and/or the application of heat to regulate the balance of Qi (energy), improve organ function and improve health.

I acknowledge that, although rare, certain side effects may result from Acupuncture, health therapy and Chinese Herbal Medicine. These may include minor bruising, minor bleeding, some pain at the site of needle insertion, infection, needle sickness (dizziness or fainting) or broken needles. These events are unusual and of short duration. Rare but potential side effects of heat therapy include heat discomfort or burning. Side effects of Chinese Herbal Medicines are rare but may include allergic reactions. Strong cleaning responses to Acupuncture and Chinese Herbal Medicine may also occur. Potential side effects will be addressed.

I am choosing Acupuncture and/or Chinese Herbal Medicine treatment as an exercise of my right to freedom of choice in the healing arts.

Patient Signature (or Legal Guardian)

Date