PATIENT INFORMATION | RIZZO CHIROPRACTIC
Brian Rizzo, DC, ART
540 Castro Street
San Francisco, CA 94114
(415) 621-5772 | phone

Welcome to our office! Please provide us with the following information for our records.

Date:_____

Name:_____ Prefer to be called: _____
LAST FIRST MIDDLE

Address:_____

City:_____ State:_____ Zip:_____

Email: _____

Home Phone:( ) _____ Work Phone: ( ) _____

Cell Phone:( ) _____

Which is the best number to contact you or to leave a message? ☐ Home ☐ Work ☐ Cell

Birth Date:_____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ P ☐ D ☐ W

Occupation:_____ Employer: _____

Employer Address/City/State/Zip:_____

In Case of Emergency-Contact:_____

Relationship:_____

Home Phone:( ) _____ Cell/Work Phone: ( ) _____

Referred By:_____

Physician's Name and Address:_____

PATIENT EVALUATION | RIZZO CHIROPRATIC
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Name: _____ Date: _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below please describe the present complaint(s) that brought you to this clinic for chiropractic care. The information you provide concerning the past and present symptoms assist your doctor in obtaining an early understanding of your state of health.

1. Present Complaint: _____

2. Please describe the character of your current pain (you may check one or more answers): ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

4. How bad is your pain or ache? Please check a number: ☐ 0 NO PAIN ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 UNBEARABLE

5. Since your problem began the pain is: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. Did your problem begin: ☐ Immediately after a specific accident ☐ Multiple incidents ☐ Gradually developed over time

7. When did your problem begin? (list specific date if possible): _____

8. Describe how your problem began: _____

9. What treatment have you received for this present condition? ☐ None ☐ Therapy from PT ☐ A back support ☐ Surgery ☐ Spinal injections
Other: _____

10. Were you previously treated for a different occurrence of this same condition? ☐ Yes ☐ No If yes, by: ☐ Chiropractor ☐ MD ☐ Therapy
Other: _____ Specify dates and type of treatment: _____

11. What makes your problem better? ☐ Nothing ☐ Laying down ☐ Walking ☐ Standing ☐ Movement/Exercise ☐ Inactivity
Other: _____

12. What makes your problem worse? ☐ Nothing ☐ Laying down ☐ Walking ☐ Standing ☐ Movement/Exercise ☐ Inactivity
Other: _____

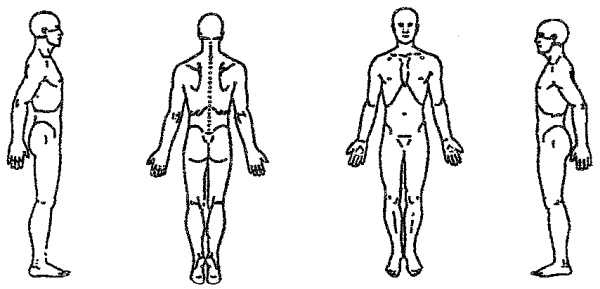
13. How would you grade your stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

14. Physical activity at work: ☐ Sedentary (More than 50% of Workday) ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

15. General physical activity: ☐ No Regular Exercise Program ☐ Light Exercise program ☐ Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active? ☐ No effect ☐ Some physical restrictions (able to do light duty tasks) ☐ Need limited assistance with common everyday tasks ☐ Need assistance often ☐ Have a significant inability to function without assistance ☐ Am totally disabled (impaired)/Cannot care for self

Mark an X on the picture where you continue to have symptoms – including pain, numbness, tingling etc.



Do you want further information/or have additional questions regarding:

_____

Any suggestions how we can improve our service to you and to others:

_____

Patient's Signature: _____ Date: _____

HEALTH HISTORY | RIZZO CHIROPRACTIC
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Name: _____ Date: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

☐Yes ☐No AIDS/HIV	☐Yes ☐No Diabetes	☐Yes ☐No Measles	☐Yes ☐No Rheumatic Fever
☐Yes ☐No Alcoholism	☐Yes ☐No Emphysema	☐Yes ☐No Migraine Headaches	☐Yes ☐No Scarlet Fever
☐Yes ☐No Allergy Shots	☐Yes ☐No Epilepsy	☐Yes ☐No Miscarriage	☐Yes ☐No Stroke
☐Yes ☐No Anemia	☐Yes ☐No Fractures	☐Yes ☐No Mononucleosis	☐Yes ☐No Suicide Attempt
☐Yes ☐No Anorexia	☐Yes ☐No Glaucoma	☐Yes ☐No Multiple Sclerosis	☐Yes ☐No Thyroid Problems
☐Yes ☐No Appendicitis	☐Yes ☐No Goiter	☐Yes ☐No Mumps	☐Yes ☐No Tonsillitis
☐Yes ☐No Arthritis	☐Yes ☐No Gonorrhea	☐Yes ☐No Osteoporosis	☐Yes ☐No Tuberculosis
☐Yes ☐No Asthma	☐Yes ☐No Gout	☐Yes ☐No Pacemaker	☐Yes ☐No Tumors or Growths
☐Yes ☐No Bleeding Disorder	☐Yes ☐No Heart Disease	☐Yes ☐No Parkinson's Disease	☐Yes ☐No Typhoid Fever
☐Yes ☐No Breast Lump	☐Yes ☐No Hepatitis	☐Yes ☐No Pinched Nerve	☐Yes ☐No Ulcers
☐Yes ☐No Bronchitis	☐Yes ☐No Hernia	☐Yes ☐No Pneumonia	☐Yes ☐No Vaginal Infections
☐Yes ☐No Bulimia	☐Yes ☐No Herniated Disk	☐Yes ☐No Polio	☐Yes ☐No Venereal Disease
☐Yes ☐No Cancer	☐Yes ☐No Herpes	☐Yes ☐No Prostate Problem	☐Yes ☐No Whooping Cough
☐Yes ☐No Cataracts	☐Yes ☐No High Cholesterol	☐Yes ☐No Prosthesis	☐Yes ☐No Other _____
☐Yes ☐No Chemical Dependency	☐Yes ☐No Kidney Disease	☐Yes ☐No Psychiatric Care	_____
☐Yes ☐No Chicken Pox	☐Yes ☐No Liver Disease	☐Yes ☐No Rheumatoid Arthritis	_____

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Are you pregnant? ☐Yes ☐No Due Date _____

Describe Injuries/Surgeries you have had:	Date:
Falls _____	_____
Head Injuries _____	_____
Broken Bones _____	_____
Dislocations _____	_____
Surgeries _____	_____

FINANCIAL POLICY | RIZZO CHIROPRACTIC
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The purpose of the following agreement is to help serve you.

PAYMENT OF BILLS - Charges for visits/treatments must be paid in full at the time of service. We expect you to honor the financial agreements you make with our office. Private insurance companies will not be billed.

MISSING OR CHANGING APPOINTMENTS - If you miss an appointment or cancel with less than 24-hour notice, there will be a full visit charge.

PROGRESS EVALUATIONS AND RE-EXAMINATIONS - During your treatment series, progress evaluations and check-ups may take place. Depending on the complexity/length of time for these visits, additional fees may apply.

I have read the above and I understand and accept these policies.

_____

Signature of Patient, Guardian, or Conservator

_____

Patient's Printed Name Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

To the patient (or their parent, legal guardian, court appointed conservator, or agent): Please read this entire form prior to signing it. It is important that you understand the information contained in this form. Please ask any questions prior to signing this form if you are unclear about anything in this form.

Chiropractic Adjustments: The primary treatment render by the Doctor of Chiropractic to you will be chiropractic adjustments, which are purposely intentioned movements of bones with the desired effect being to remove interference to nerves, which then allows your body to use its innate ability to heal itself. Chiropractic adjustments also have the desirable effect enabling muscles, tendons, and ligaments to properly function and heal, and also allows blood flow to properly occur. Chiropractic adjustments can be made by either the use of hands or mechanical instruments to any bone or joint in the body including both spinal and extremity bones. You may or may not hear an audible sound, which is just air being released from the joint space as bones are moved into their proper positions.

Other Procedures: There are a number of other procedures used by Doctors of Chiropractic that may be used on you. A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, range of motion testing, muscle strength testing, various neurological and orthopedic testing, and other testing. Radiology is the use of x-rays on the human body and is used to gain an inside perspective of the human body that cannot be obtained from a physical examination. Treatment may include chiropractic adjustments, physical therapy (such as ultrasound, interferential therapy, massage therapy, exercise recommendations, etc.). Additionally, there may referrals to other doctors as necessary, and their treatment should involve the same informed consent with disclosure of risks and benefits as is being done here. For example, there can be permanent pain as a side effect of surgery as one possible consequence of that procedure.

Potential Benefits of Chiropractic and Associated Care: The vast majority of chiropractic patients tend to achieve good to excellent improvement in their physical conditions with chiropractic care. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and other ways. It must be remembered that different people get different results, different people have different pre-existing conditions, and are of different ages and occupations (with different types of physical stress). Your situation is unique, and no guarantees are given. You will have to determine what results you get for yourself and report them to your Doctor of Chiropractic.

Material risks Inherent with Chiropractic Adjustments and Other Treatment: As with any healthcare procedure, there are certain complications that may arise when chiropractic adjustments and other care/procedures are performed. These complications include but are not limited to fractures of bones, disc injuries, dislocations, muscle strains, cervical myelopathy, strokes, radiation exposure, costovertebral strains and separations, and burns. Some patients feel some stiffness and/or soreness following the first few days of treatment. The physical exam can temporarily worsen symptoms, but is a necessary part of chiropractic care. The Doctor of Chiropractic will make every reasonable effort during the examination to screen for contraindications to care, but remember it is your responsibility to inform the Doctor of Chiropractic of any conditions that would not otherwise come to their attention.

Probability of Risks Occurring: Fractures are rare occurrences and generally result from some underlying weakness of bone. Even though a competent history, examination (which may include radiography) will be performed, it is still possible for some weaknesses of bone to be undetected. Extremely rare are strokes from vertebral artery dissection that also occur in about one person in 133,000 in general (not related to chiropractic), but are estimated to occur in between one in one million and one in five million cervical adjustments. Although discs are generally helped with chiropractic care, they can be worsened even to the point of requiring surgical care (although this rarely occurs). Physical therapy can sometimes burn skin by irritating it, although this is unlikely to occur. A perspective on the risks of chiropractic care as compared to medical care can been seen by the money paid by different doctors for a $1,000,000 malpractice liability policy. The following annual premiums listed are close approximations, although not exact. A general medical doctor pays about $20,000 per year, an internal medicine specialist pays about $50,000 per year, and medical specialists such as surgeons, cardiologists, and obstetrics and gynecologists (OBGYN) pay about $150,000 per year for a $1,000,000 malpractice liability policy. In stark contrast to medical doctors who patients encounter significant more risk that Doctors of Chiropractic, Doctors of Chiropractic in California pay about $3,000 per year. Also, it has been reported that about 187,000 deaths occur every year from medical malpractice, but that the number for chiropractic is typically zero per year.

Consequences of Not Obtaining Chiropractic Care: Not obtaining chiropractic care will have the effect of not obtaining its benefits such as having your body function at its best ability, reducing pain, peak athletic performance, etc. Not obtaining chiropractic care may allow formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult, requiring more time (and money), and less effective when chiropractic care is obtained later in time. Not obtaining chiropractic care following trauma such as whiplash or other effects of automobile accidents will cause injured muscles, tendons, and ligaments to heal improperly and be significantly weaker and more prone to re-injury as compared to receiving proper chiropractic care.

Alternatives to Chiropractic Care: Other treatment options for your condition may include rest, acupuncture, physical therapy, medical care, medications (both over the counter and prescribed), hospitalization, and surgery, and others. If you choose to use other treatment options, you should discuss the risks and benefits with your medical doctor or other provider.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM. UPON DOING SO, PLEASE COMPLETE THE INFORMATION AND SIGN THIS FORM.

_____

Signature of Patient, Guardian, or Conservator

_____

Patient's Printed Name Date

HEALTH PRIVACY POLICY

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 Rizzo Chiropractic, we may use or disclose personal and health related information about you in the following ways:

- Your personal 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, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services.)
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message maybe left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.
- Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:
    - If we are providing health care services to you based on the orders of another health care provider.
    - 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 to 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 any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care 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 different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or 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 of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

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 Dr. Brian Rizzo.

If you would like further information about our privacy policies and practices please contact: Dr. Rizzo This notice is effective as of April 2003. This notice, 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.

_____

Signature of Patient, Guardian, or Conservator

_____

Patient's Printed Name Date