REGEN SPINE AND NERVE

Today's Date: __/__/____

1. Please enter your information.

First Name: _____ Last Name: _____ Date of Birth: _____ Gender: ○ Female ○ Male

Mobile Phone: _____ Email: _____ Address: _____ City, State: _____

Zip: _____ Retired? ○ Yes ○ No Occupation: _____ Marital Status: ○ Single ○ Married ○ Widowed ○ Other

Spouse/Partner Name: _____ Phone Number: _____ How Did You Hear About Us? _____

2. What is your primary symptom?

_____

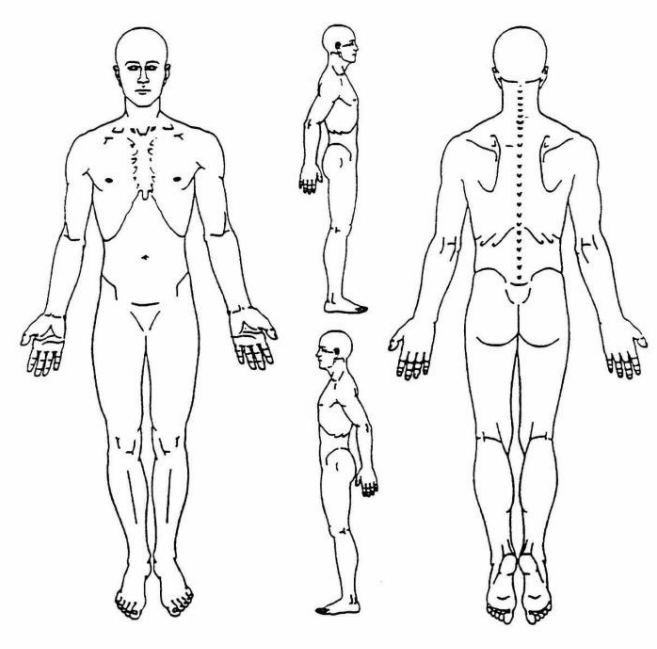
3. How long have you been dealing with your primary symptom?

_____

4. On a scale 0-10 (10 = Emergency room), how would you rate your primary symptom?

_____

5. Use the diagram to outline your primary symptom:



6. Have you had any sport injury, fall, and/or car accident? (If so, list what body part(s) got injured)

_____

7. What makes your primary symptom worse?

8. What makes your primary symptom better ?

9. What do YOU think is the main cause of your primary symptom?

10. What activities, hobbies, and/or events have you had to discontinue because of your primary symptom?

11. Is there a secondary symptom that is also a problem?

- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Sciatica
- ☐ Shoulder Pain
- ☐ Low Back Pain
- ☐ Knee Pain
- ☐ Hand Pain
- ☐ Hip Pain
- ☐ Foot Pain

12. Select all that you may currently have:

- ☐ Deep Vein Thrombosis
- ☐ Loss of Bowel Control
- ☐ Cancer/Chemotherapy
- ☐ Open Wounds
- ☐ Liver Disease
- ☐ Defibrillator
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Excessive Thirst / Urination
- ☐ Loss of Bladder Control
- ☐ Recent Fractures
- ☐ None apply to me

13. In the last 3 months, have you had an MRI of your neck or low back? If so, when and where?

14. List any joint(s) that have been replaced or where you may have surgical screws/metal:

15. What medications are you currently taking?

16. Daily habits play a significant role on helping us or hurting us to function and heal. Select all that apply:

- ☐ Drinking Alcohol
- ☐ Minimal/Zero Exercise
- ☐ Prolong Sitting
- ☐ Negative Thinking
- ☐ Side/Stomach Sleeping
- ☐ High Sugar Intake
- ☐ Low Water Intake
- ☐ Poor Nutrition
- ☐ Smoking

GUT WELLNESS ASSESSMENT

Please complete this assessment so we can thoroughly evaluate what may be an underlying contributor to your symptoms, known as "Leaky Gut".

17. Select all that apply:

- ☐ ADD / ADHD
- ☐ Autism
- ☐ Chronic Fatigue
- ☐ Crohn's Disease
- ☐ Confusion
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emotional Imbalance
- ☐ Fibromyalgia
- ☐ Frequent Migraines
- ☐ Intestinal Disorders
- ☐ Irregular Bowel Movements
- ☐ Irritable Bowel Syndrome
- ☐ Lupus
- ☐ Pre-Diabetes
- ☐ Rheumatoid Arthritis
- ☐ Ulcerative Colitis
- ☐ None apply to me

18. Complete this assessment and select the number that is most accurate.

	NA	1-2x's/Month	3-5x's/Month	6+ x's/Month
Constipation and/or Diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3
Ulcerative Colitis or Celiac Disease	0	1	2	3
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

19. By printing/signing my name below, I authorize that all the information stated above is factual regarding my personal information and past/current state of health.

Full Name _____ Date _____

HIPAA NOTIFICATION

Notice of Privacy Practices:California

YOUR INFORMATION - YOUR RIGHTS - OUR RESPONSIBILITIES
This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully: Regen Spine and Nerve is committed to protecting the privacy of your identifiable health information. The information is known as “protected health information” or “PHI”. At Regen Spine and Nerve PHI is stored electronically and is subject to electronic disclosure. Examples of documents that may contain your PHI include exam orders, intake forms, exam results, and billing invoices.

OUR RESPONSIBILITIES
We are required by law to maintain the privacy of your PHI. We are also required to provide you with a copy of this Notice upon your request. It describes our legal duties, privacy practices, and your patient rights as provided by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). We are required to follow the terms of this Notice and to notify patients impacted by an unauthorized use or disclosure compromising the security or privacy of unsecured PHI.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION We use your PHI for treatment, payment, and healthcare operations purposes, and for other purposes permitted or required by law. Not every use or disclosure is listed in this notice, but all of our uses or disclosures of your PHI will fall into one of the categories listed below. We need your information to use or disclose your PHI for any purpose not covered by one of the categories below. With limited exceptions as permitted by HIPAA, we will not use or disclose your PHI for marketing purposes or sell your PHI unless you have signed an authorization. You may revoke any authorization you sign at any time. If you revoke your authorization, we will no longer disclose your PHI except to the extent we have already taken action based on your authorization.

We may use and disclose your PHI for the following purposes:

Treatment - We disclose your PHI to healthcare professionals who order procedures or need access to your results for treatment purposes. We may use your PHI to contact you to remind you of an appointment or to tell you about health-related products and services that may be of interest to you.

Payment - We may use and disclose your PHI for purposes of billing and payment. For example, we may send invoices to you if you have a balance for your treatments.

Healthcare Operations - We may use and disclose your PHI for activities necessary to support our healthcare operations, such as performing quality assurance checks on our services, internal audits, accreditation audits, and arranging legal services.

Business Associates - We may provide your PHI to third parties to perform certain services for us. These other entities, known as “business associates”, are required to maintain the privacy and security of all PHI. For example, our business associates may use or share your PHI to conduct billing, collections, courier, or record storage services on our behalf.

As Required by Law, Law Enforcement Activities, and Legal Proceedings - We may use and disclose your PHI as required by law. We may use and disclose your PHI if necessary to prevent or lessen a serious threat to your health and safety or that of another person. We may also provide PHI to law enforcement officials, for example, in response to a warrant, investigative demand or similar legal process, or for officials to identify or locate a suspect, fugitive, material witness, or missing person. We may disclose your PHI as required to comply with a court or administrative order, or in response to a subpoena, discovery request or other legal process in the course of a judicial or administrative proceeding, but only if efforts have been made to tell you about the request or to obtain an order of protection for the requested information.

Individuals in Your Care - We may disclose relevant PHI to a family member, friend, caregiver, or other individual involved in your healthcare or payment for your healthcare, if you tell us that this is acceptable to you or you do not object; or if in our professional judgment, we believe that you do not object.

Other Uses and Disclosures - As permitted by HIPAA, we may disclose your PHI to Social Services Agencies, Public Health Authorities, The Food and Drug Administration, Health Oversight Agencies, Military Command Authorities, National Security and Intelligence Organizations, Correctional Institutions, Organ and Tissue Donation Organizations, and Workers Compensation Agents. We may also disclose PHI to those assisting in disaster relief efforts so that family or friends can be notified about your condition, status, and location.

Incidental Uses and Disclosures - Your PHI may be used or disclosed in the course of conducting business. For example, we may call your name in the waiting room, or use it in a telephone conversation with a provider. We are permitted to make such incidental uses and disclosures as long as we take reasonable steps to minimize them, and have appropriate safeguards in place.
Note Regarding State Law - For all of the above purposes, when state law is more restrictive than federal law, we are required to follow the more restrictive state law.

YOUR PATIENT RIGHTS

- **Obtain an electronic or paper copy of your medical record**
- **Ask us to amend your medical record**
- **Request confidential communications**
- **Ask us to restrict what we use or share**
- **Obtain an accounting of disclosures**
- **Obtain a copy of this Notice of Privacy Practices**
- **Choose someone to act for you**
- **For certain health information, you can tell us your choices about what we share**

If you believe your privacy rights have been violated, you have the right to file a complaint with us, or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, or should you have any questions about this notice, send an email to us at info@regenspinenerve.com or write to the following address:

Regen Spine and Nerve
Attn: Manager
1590 E. Main St.
Ventura, CA 93001

You may also contact the clinic manager by phone at (805) 648-7987 Regen Spine and Nerve will review its Notice of Privacy Practices on at least an annual basis, and may also change this notice at any time. If we make changes, we will revise the “Last Updated” date at the bottom of this notice. **Last revised on 03/07/2024*

Patient Signature: _____ Date: _____

REGEN SPINE AND NERVE

INFORMED CONSENT TO TREATMENT

Initial:

_____The details of the treatment have been explained to me in terms I understand.
_____Alternative methods and their disadvantages or benefits have been explained to me.
_____I understand and accept that possible risks & complications include, but are not limited to:
-Fatigue following a session
-Treatment unsuccessful in its intended purpose/no relief
-Worsening of condition being treated
-Radiating discomfort
_____I have informed the doctor of all previous operations, including but not limited to spinal fusion, acute fractures, and dislocations.
____ I have informed the doctor of my past medical history, including but not limited to history of diabetes, cancer, hypertension and/or cardiac conditions.
_____I have informed the doctor whether I have musculoskeletal problems, such as skin, bone, or joint infections, bone cancer, acute rheumatoid arthritis and/or disease of the spinal cord or bone marrow.
_____I certify that I do not have a pacemaker with a defibrillator.
_____I am aware and accept that no guarantees about the results of the treatment have been made.
_____I have been informed of what to expect post treatment, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional treatments.

I hereby request and voluntarily consent to the rendering of care, including treatment and performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnosis x-ray(s) and other physical therapy techniques, on me (or the patient named below for which I am legally responsible) which are recommended by the Doctor 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.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, 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 procedure(s) 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 and/or with office personnel the nature, 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 certify that I have read the above explanation of the chiropractic adjustment and related treatment. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). I hereby authorize the doctor to treat my condition as he/she deems appropriate. I understand that no diagnosis, treatment, or cure of any disease, including cancer of any type, or condition is implied. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Having been informed of the risks, 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 treatment recommended. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Regen Spine and Nerve
1590 E. Main Street
Ventura, CA 93001

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Printed Name of Patient Signature of Patient Date

Signature of Patient's Representative (if minor or physically incapacitated)

Witness to Patient's Signature Date

I certify that I have explained the nature, purpose, benefits, risk, complications and alternative to the proposed patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative fully understands what I have explained.

Doctor's Signature