Today's Date: ____________________

Neuropathy Consult ROF

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name: ______________________________ **Nickname:** ____________________

Address: ____

City: ______________ **State:** ________ **Zip Code:** ________________

Phone: _____________________ **Email:** ______________________________

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth: ______________ **Social Security:** ____________________

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse Name: ____________________ **Phone Number:** _______________

Your Occupation: ____________________ **Retired:** Yes ☐ No ☐

REVIEW OF SYMPTOMS

Please check all that apply

- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Pacemaker/ Defibrillator
- ☐ Herniated Disc
- ☐ Bulging Disc
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Vascular Problems
- ☐ Leg Pain
- ☐ Morton's Neuroma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Implanted Cord/ Bladder Stimulator
- ☐ Arthritis in Hands
- ☐ Arthritis in Feet
- ☐ Plantar Fasciitis
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor Wound Healing
- ☐ Excessive Thirst or Urination

PRESENT HEALTH CONDITION

01 In order of importance, list the health problems you are most interested in getting corrected:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

02 Is there a certain time of day any of these problems are better or worse?

____
____
____
____

03 Is your balance/walking ability affected? If yes, please describe:

____
____
____
____

04 List approximately how long you have noticed these problems in your life:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

05 Circle the things you have used for these problems:

Gabapentin Neurontin Lyrica
Cymbalta Physical Therapy Pain
Medications Aleve Tylenol
Ibuprofen Motrin Chiropractic
Massage Therapy Injections Creams

06 What do you think is causing your problem?

____
____
____
____

07 Name of all doctors you have seen for these problems and treatment you received

____
____
____
____

08 **Have your symptoms:** Improved ☐ Worsened ☐ Stayed the Same ☐

List anything that makes your condition worse ______________________________

____

List anything that makes your condition better ______________________________

____

09 **How would you describe the symptoms? Please check ALL that apply:**

☐ Aching Pain	☐ Tingling/Electric Shocks	☐ Dead Feeling
☐ Stabbing Pain	☐ Pins & Needles Pain	☐ Cold Hands/Feet
☐ Sharp Pain	☐ Heavy Feeling	☐ Cramping
☐ Tiredness	☐ Hot Sensation	☐ Swelling
☐ Numbness	☐ Throbbing Pain	☐ Burning

10 **Is this condition interfering with any of the following?**

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

SOCIAL HISTORY

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes daily? __________

Do you drink? Yes ☐ No ☐ If yes, how many drinks per week? __________

Do you exercise? Yes ☐ No ☐ If yes, please describe type and how often?

____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

If you had to accept some level of pain after completion of treatment, what would be an acceptable level

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

PREVIOUS HEALTH CONDITIONS

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name: ______________________ **Signature:** ______________________

Please give name, address, and office phone number of your primary care physician.

Name: ____________ **Phone:** ____________ **Address:** ______________________

When were you last seen there? ______________________

May we send them updates on your treatment/condition? Yes ☐ No ☐

List ALL allergies/sensitivities to medication, food, and other items here:

Items you react to:	Reaction:

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Time Daily

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

Today's Date: ____________

Patient Quality of Life Survey

Company Information: ______________________________

Name: ______________________ **Date:** ____________

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other (please specify): ______________________

02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Some Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did Not Get Worse
- ☐ Did Not Work Very Long
- ☐ Still Trying
- ☐ Confused

03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ Haven't Noticed Any Problem
- ☐ They Tell Me To Do Something
- ☐ People Avoid Me

04 What are you afraid this might be (or beginning) to affect (or will affect)?

- ☐ Job
- ☐ Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self-Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

05 Are there health conditions you are afraid this might turn into?

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

06 How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

____

____

____

____

07 What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:

1. ____
2. ____
3. ____

08 What are you most concerned with regarding your problem?

09 Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

10 What would be different/better without this problem? Please be specific.

11 What do you desire most to get from working with us?

12 What would that mean to you?

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: _____________

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