Welcome to the office! Your first visit is an opportunity for us to learn all about you, your health history & health goals. Congratulations on taking your first steps toward higher levels of health, wellness and wholeness.

Awaken Wellness
251 Park Road, #150
Burlingame, CA 94010
(650) 688-2020
www.awakenwellnesschiropractic.com

Personal Information

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____ City,State_____ Zip code _____

Email Address _____ Social Security # _____

DL# _____

Whom may we thank for referring you to our center? _____

Marital status: ☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced Spouse/Partner's Name _____

Children: # of Kids ____ How many at home? _____ Names & ages _____

Work status: ☐ employed ☐ self-employed ☐ retired ☐ student ☐ unemployed ☐ other _____

Occupation: _____ Employer: _____

• Primary healthcare advisor name: _____ address: _____

• Previous chiropractor: name/address: _____ results? _____

• Have you ever been told you have any problems/defects in your spine or nervous system? ☐ Yes ☐No
If yes, please explain _____

Primary Health Insurance: Name of insured: _____

Insurance co: _____ DOB: _____

policy #: _____ group # _____ _____

IN CASE OF EMERGENCY

Emergency contact: _____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

TREATMENT OF MINORS:

I _____ hereby authorize Lorraine Sarullo, D.C. and authorized Awaken Wellness Chiropractic staff, to administer chiropractic care as deemed necessary to my son/daughter _____.

Parent/guardian signature:_____ date:_____

Please check if you are here for: ☐ Motor Vehicle Injury ☐ Work Injury ☐ Other Injury _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

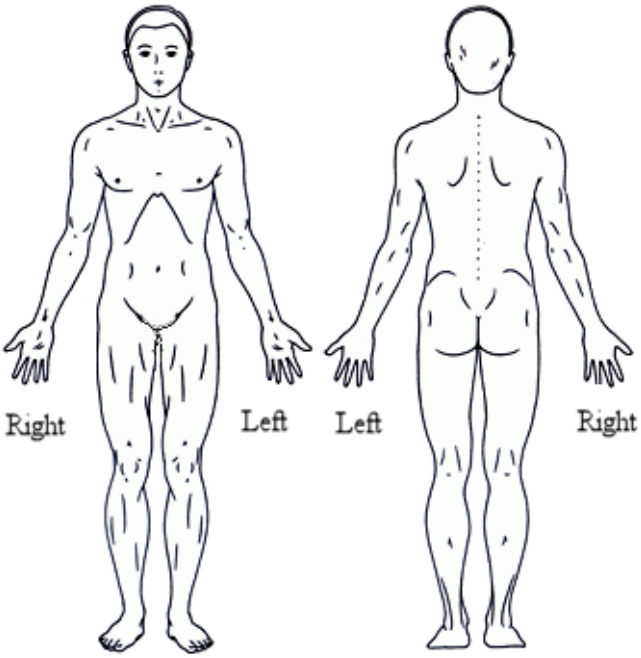
I understand this office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature _____ Date _____

Guardian's Signature _____ Date _____

Please mark any complaints on the pictures below: indicate chief complaint



Please complete for each numbered complaint:

1. **Chief Complaint**: _____

Onset: (how/when it started)

Severity: (least) 1 2 3 4 5 6 7 8 9 10 (worst)

Function: (least) 1 2 3 4 5 6 7 8 9 10 (worst)

Quality: ache (dull/sharp) numbness tingling burning pins/needles
other: _____

Worsened by: sitting standing bending lying down

Relieved by: ice heat rest exercise massage chiropractic
other: _____

Radiation: _____

Other details: _____
_____
_____

Other Complaints:

	2.	3.	4.	5.	6.
Onset:					
Severity:					
Quality:					
Worsened by:					
Relieved by:					
Radiation:					

Personal Health History

Please list and explain all instances:

- **Injuries, Falls or Traumas:**

- **Motor Vehicle Accidents:**

- **Illnesses/Hospitalizations:**

- **Surgeries:**

- **Please list your current medications and what they are taken for:**

- **Vitamins and Minerals:** (please list your current supplements and whether prescribed):

Health Habits

Smoking	□ None □ Yes How much per week? What kind?
Alcohol	□ None □ Yes How much per week? What type?
Coffee	□ None □ Yes How much per week?
Exercise	□ None □ Yes How much per week? What kind?
Soft Drinks	□ None □ Yes How much per week?
Water	How much per day?
Sleep	Average hours per night? Difficulty falling asleep or staying asleep? Position you sleep in:
Eating	Meals per day? Do you consider your diet healthy? □ Yes □ No Explain: What types of food do you eat?

Have any of your FAMILY MEMBERS ever suffered from any of the following conditions? Mark relationship in the blank space.

□ Diabetes _____ □ Heart Disease _____
□ Stroke _____ □ Neurological Disorders _____
□ Autoimmune Disorders_____ □ Cancer_____
□ Other _____

Check the left box for any condition you had in the **P**ast, and the right box for any condition that is **C**urrent.

GENERAL HEALTH HISTORY

P C	P C	P C	P C
□ □ Traumas (falls, MVAs)	□ □ Freq. colds/flus, poor immunity	□ □ Tuberculosis/Lung Con	□ □ Lymph conditions
□ □ Head injuries	□ □ Intolerant of heat/cold	□ □ Lung Conditions	□ □ Skin conditions
□ □ Mental Disorders	□ □ Anemia	□ □ Rheumatic Fever	□ □ Diabetes
□ □ Stress, anxiety, worry	□ □ Thyroid Disease	□ □ Fungal Infection	□ □ Autoimmune Disease
□ □ Allergies	□ □ Hepatitis ____	□ □ Chicken Pox	□ □ Bone Disease/Osteoporosis
□ □ Asthma	□ □ Herpes	□ □ Cancer/ Tumors	□ □ Swelling /inflammation
□ □ Traumas (falls, MVAs)	□ □ Freq. colds/flus, poor immunity	□ □ Tuberculosis/Lung Con	□ □ Lymph conditions

NERVOUS SYSTEM

P C
□ □ Depression
□ □ Memory Loss
□ □ Confusion
□ □ Dizziness
□ □ Fainting
□ □ Convulsions
□ □ Weakness
□ □ Poor Balance
□ □ Twitches/Tremor
□ □ Cold/tingle Extremities
□ □ Sleeping Difficulties
□ □ Headaches

CARDIOVASCULAR

□ □ Heart Disease
□ □ Chest Pain
□ □ Irregular Heartbeat
□ □ High blood pressure
□ □ Low blood pressure
□ □ Shortness of Breath
□ □ Varicose Veins
□ □ Ankle Swelling
□ □ Lung/Congestion Prob

MUSCULOSKELETAL

P C
□ □ Arthritis/DJD
□ □ Skull/Face pain
□ □ Jaw Pain/TMJ
□ □ Neck Pain
□ □ Shoulder pain
□ □ Arm/Elbow Pain
□ □ Wrist/Hand Pain
□ □ Mid Back Pain
□ □ Lower Back Pain
□ □ Hip pain
□ □ Thigh/Leg/Knee Pain
□ □ Ankle/Foot Pain
□ □ Leg/Arm Fatigue
□ □ Difficulty Walking
□ □ Osteoporosis
□ □ Bone Disease

REPRODUCTIVE

□ □ Sexual Dysfunction
□ □ Venereal Infection
□ □ Erectile Difficulties
• Females only:
□ □ Menstrual Cramping
□ □ Menstrual Irregularity

GASTROINTESTINAL

P C
□ □ Poor/Excess Appetite
□ □ Excessive Thirst
□ □ Frequent Nausea
□ □ Hemorrhoids
□ □ Black/Bloody Stools
□ □ Digestive Problems
□ □ Abdominal Cramping
□ □ Gas/Bloating
□ □ Heartburn
□ □ Weight Problems
□ □ Gall Bladder Problems
□ □ Liver Problems
□ □ Diarrhea
□ □ Constipation

Bowel movement frequency:

Bowel movements consistent?

Do your stools float or sink?

EYES/EARS/NOSE/THROAT

P C
□ □ Vision Problems
□ □ Flashing Lights/ Black Spots
□ □ Blurriness
□ □ Glaucoma
□ □ Ringing in Ears
□ □ Hearing Loss
□ □ Swallowing Difficulty

GENITOURINARY

□ □ Bladder Trouble
□ □ Painful Urination
□ □ Discolored Urine
□ □ Incontinence

- How many times per day do you urinate?
- Do you experience any urgency, dribbling, or incontinence?
- Is this urination pattern consistent? Yes No

- Females only:

When did your menses first: begin?_____ end? _____
Last menstrual cycle began: _____
Pregnancies? _____ # of children _____

Any Swelling or inflammation? Yes No Location:
Other:

Notice of Privacy Practices

Your personal privacy is very important to us. We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used to provide treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition we may share your health information with referring physicians, clinical laboratories or other health care personnel providing you treatment.

To Obtain Payment: We may include your health information with an invoice used to collect payment for future treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

To Conduct Health Care Operations: Health information may be included in training programs for interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders: we believe regular care is very important to your general health, we will remind you of a scheduled appointment or when it is time to make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family, include postcards, mailers, letters, telephone reminders or electronic reminders such as e-mail (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect: we will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment or when we believe we are specifically required or authorized by law.

Public Health and National Security: we may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic.

For Law Enforcement: as permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purpose, including under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Open Adjusting Areas: our center allows for the treatment of multiple patients in the office at the same time and includes an open adjusting area, which is used when necessary. If you do not wish to have your appointment during open adjusting times, nor in the semi-private curtained area while other patients are present, please notify us when making your appointments. We will provide set times for your request.

Authorization of Use to Disclose Health Information: other than what is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights:

- *You have the right* to request restriction on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.
- *You have the right* to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.
- *You have the right* to read, review and copy your health information, including your complete chart, x- rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.
- *You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.
- *You have the right* to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentations procedures will enable us to provide information on health information usage from the date of first appointment and forward. Please let us know in writing the time period for which you are interested.
- *You have the right* to obtain a copy of this Notice of Privacy Practices directly from our office at any time.
- *You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

We are required by law to maintain the privacy or your health information and to provide to you and your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our Privacy Practices we will be sure all of our patients receive a copy of the revised Notice.

Patient Acknowledgment

Thank you very much for taking time to review how we are carefully using your health information. If you have a complaint regarding any aspect of our privacy policies, or if you would like further information about them, please contact Dr. Sarullo. If not we would appreciate very much you acknowledging your receipt of our policy by signing, dating, and returning this Notice.

Patient Signature _____ **Date** _____