Dr. Barbara Berkeley
Chiropractor

977 Valencia St.
San Francisco, Ca 94110
415 285 2500

FOR DOCTOR ONLY, DIAGNOSIS:_____, _____, _____

Name_____ Date_____

Home Address_____

City_____ Zip Code_____

Primary Phone (____) _____ Home/Cell *(Please circle)*

Secondary Phone (____)_____ Work/Cell *(Please circle)*

Birth Date_____ Age____ Email _____
(Optional)

Occupation_____ Employer _____

Work Address_____

Emergency Contact_____ Relationship_____

Home Phone__(____)_____ Work Phone___(____)_____

Referred by_____

Do you need an insurance receipt? *(Please circle)* **Yes No**
Is your insurer Blue Shield PPO? Yes No
If so, please give the office manager your Blue Shield insurance card to copy.

Is your current condition due to:

1. A car accident or work related injury? No __ Yes __ Date _____

Describe your chief complaints in order of importance, include dates of onset:

1.
2.
3.

How do you handle stress? _____

How would you describe your general state of health?

Who is your Physician? _____ Date of last physical exam_____

Address _____

What other health practitioners are you currently seeing?

Have you ever been to a chiropractor? No _____ Yes _____ Date of last visit _____

Name _____ Address_____

Have you ever been hospitalized?

Type of operation or illness:
Month and year:
Name and address of hospital:

Do you have any history of trauma? (car accident, injury, abuse, broken bone) (describe)

List any medications / vitamin supplements / herbs / homeopathic that you are currently taking

Personal & Social History: *Please check the appropriate column if any of the following apply to you*

Past	Present					
		Tobacco	per day	_____	or per week	_____
		Alcohol	per day	_____	or per week	_____
		Drugs and related substances				
		Drug or alcohol dependence				
		Coffee / Tea / Caffeinated drinks	per day	_____	or per week	_____

How many hours of sleep do you get a night? _____ Is it enough? _____
In what position do you sleep? _____ With pillow? _____
Is your mattress firm? _____ How old is it? _____

What type of exercise do you do, and how often?

What are your work duties? (sitting, standing; lifting, driving, phone, computer) (briefly describe)

Have you ever been injured on the job before? (please circle) Yes No

Family History : Please tell us about your birth parents and blood relatives

Mother is (circle one) LIVING DECEASED Age _____ Cause of death _____

Father is (circle one) LIVING DECEASED Age _____ Cause of death _____

Please check the appropriate column if any of the following apply to your blood relatives.

	Alcoholism		High blood pressure
	Allergies		Kidney disease
	Arthritis		Cancer
	Anemia, blood, bleeding disorders		Mental illness
	Diabetes mellitus		Obesity
	Heart disease		Stroke
	Seizure disorder		Tuberculosis

Review of Systems

PATIENT NAME: _____ Date_____

Please check those problems that apply to you

General

- ☐ Fatique
- ☐ Allergies
- ☐ Easily irritated

Head

- ☐ Headache
- ☐ Head Injury
- ☐ Fainting
- ☐ Seizures

Eyes

- ☐ Last Eye exam
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wear bi-focals/progressive lenses

Ears

- ☐ Tinnitus
- ☐ Ear infection
- ☐ Loss of hearing

Nose

- ☐ Sinus Infections
- ☐ Nosebleeds
- ☐ Colds more than 3 x/yr

Mouth

- ☐ Gums bleed easily
- ☐ Sores in mouth

Neck

- ☐ Thyroid Disease
- ☐ Freq. Sore thoat
- ☐ Freq. Stiff neck
- ☐ Difficulty swallowing

Heart

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irregular heart beats
- ☐ Shortness of breath
- ☐ Heart murmur
- ☐ Chest Pain
- ☐ Swollen feet or ankles

Lungs

- ☐ Shortness of breath
- ☐ Asthma
- ☐ Chronic cough

Gastro-Intestinal Tract

- ☐ Nausea & vomiting
- ☐ Freq. Heartburn
- ☐ Diarrhea
- ☐ Constipation
- ☐ Freq. Intestinal gas
- ☐ Abdominal Pain
- ☐ Rectal itching
- ☐ Hemorrhoids

Liver and Gall Bladder

- ☐ Freq. Belching
- ☐ Hepatitis B or C

Urinary Tract

- ☐ Bladder/kidney infections
- ☐ Urine loss w/ cough or sneeze

Neuromuscular

- ☐ Arm or leg pain
- ☐ Numbness/tingling
- ☐ Fainting

Skin

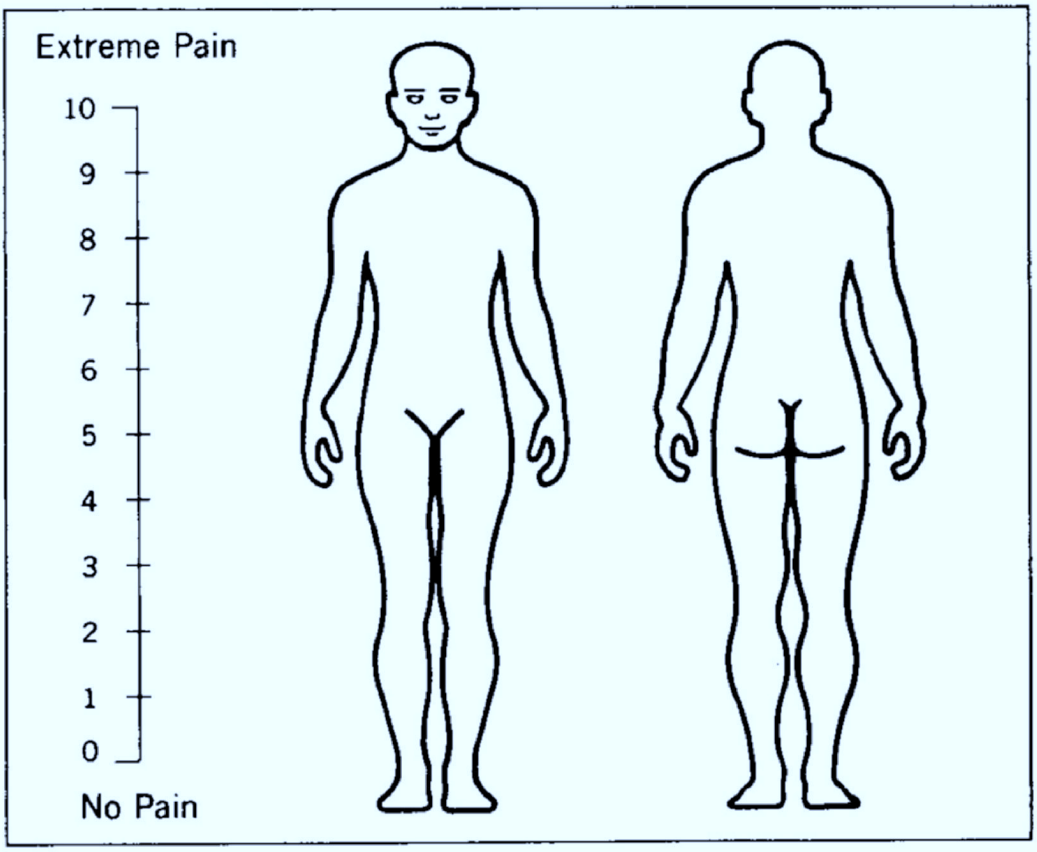
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Easy bruising

Women Only

- ☐ PMS
  - Takes the form of -
    - ☐ Breast soreness
    - ☐ Depression
    - ☐ Irritablility
- ☐ Self Breast Exam Monthly?
- ☐ Date of last Mammogram
- ☐ Family history of Breast Cancer
- ☐ Heavy menstual period
- ☐ Irregular menstrual periods
- ☐ Uterine Fibroids
- ☐ Ovarian cysts
- ☐ Herpes
- ☐ Chlamydia
- ☐ Endometirios

PAIN ASSESSMENT

Name _____ Date _____



Please indicate the areas of your pain on the figures above. Then mark the severity of your pain on the scale of 0-10.

Describe any changes in your condition or any new concerns:

_____

_____

_____

Patient Signature _____

#20440 — Medical Arts Press 1-800-328-2179

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Office Policy on Insurance Billing and Missed Appointments

Welcome to Our Office:

The office policy regarding missed appointments, or appointments that are forgotten, cancelled or changed without 24 hour notice is as follows:

Patients must reschedule or cancel appointments 24 hours in advance. If this is not done, you will be charged the full fee. This is your responsibility. Your insurance cannot be billed.

Your cooperation is greatly appreciated.

If we are billing your insurance:

I authorize the release of any medical information necessary to process my claims. I also authorize payment to be made directly to my doctor. I understand that I am financially responsible to the doctor for all charges not covered by insurance.

Office policy is for the patient to pay all charges at the time of service, depending on the type of insurance coverage you have.

Thank you.

Please sign and date indicating you have read and understand these policies.

I also acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices.

_____	_____	_____
Signature	Printed Name	Date

Dr. Barbara Berkeley
977 Valencia St.
San Francisco, CA 94110

Patient Copy

Notice of Privacy Practices

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.

This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to you past, present or future physical or mental health or condition and related health services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment We will use and disclose your protected health information to provide, coordinate, to manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you and remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse and Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: worker's Compensation: Inmates: Required uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosure Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for the notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if an, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on /or before April 14, 2003.

Dr. Barbara Berkeley
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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 rendered 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 of 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 which 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 which 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 reinjury 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, Conservator, or Agent Date

Patient's Printed Name