ACTIVE HEALTH CENTER MOUSSELI CHIROPRACTIC, CORP.

In order to provide you with the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL. We welcome you to the family.

PATIENT DATA:

Patient Name_____ Gender ☐M ☐F Date_____
Age____ Birth Date_____ Marital Status ☐S ☐M ☐D ☐W Number of Children_____
Occupation_____ Employer_____
Home Address_____ City_____ State____ Zip_____
Telephone (Work)_____ (home)_____ (Cell)_____
Email*_____ (*used for occasional office announcements and promotions only)
Emergency Contact_____ Relationship_____ Phone_____
Who is responsible for your bill, You and ☐You only ☐Auto Insur. ☐Worker's Comp. ☐Health Insur. ☐Medicare
Who is your medical doctor? _____ Telephone: _____
How did you hear about us?_____

INSURANCE INFORMATION:

****Please Note: Most insurances only pay for spinal adjustments and do not cover most of the other services we provide. You are responsible for any deductibles, co-pays and non-covered charges.****

Do you have health insurance? ☐Y ☐N Name of company _____
Telephone: _____ Group #: _____ Insured's Name: _____
Insured's SS#:_____ Insured's DOB:_____ Relation: _____

*** If an auto accident, please provide:**

Insurance Company Name _____ Contact Person _____
Phone: _____ Claim #_____ Date of Accident_____

TREATMENT: What type of treatment are you looking for?

☐I am looking for the most minimal amount of care to "patch up the symptoms" of my problem
☐I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
☐I am looking to take care of my problems and then go on to "achieve optimal Health and Wellness"*

(*If you chose to "patch up the symptoms" only, skip questions a-g.)

a. Please rate (circle) on the scale how serious you are about achieving health and wellness.

1 = Not serious……10 = very serious

1 2 3 4 5 6 7 8 9 10

b. Should you be accepted as a patient, are you willing to follow a treatment program designed to help you achieve your health goals for at least 3 months if needed? ☐Y ☐N

c. Are you willing to make dietary changes if needed? ☐Y ☐N

d. Are you willing to begin and maintain a moderate exercise program if needed? ☐Y ☐N

e. Health and wellness not only include diet and exercise, but also often involve a change in thought and attitude, are you willing to make changes to your thoughts and attitude? ☐Y ☐N

f. Are you willing to make reasonable changes to you daily lifestyle if needed? ☐Y ☐N

g. What's your physical activity goal if this problem is corrected?_____

CASE HISTORY:

HEALTH CONCERNS: Please list your Top Health Concerns in order of priority, When they started and Grade them on a scale of 1 to 10 (1 = virtually not a problem….10 = thoughts of suicide it's so bad).

	Date of Onset	Grade
1)_____	_____	1 2 3 4 5 6 7 8 9 10
2)_____	_____	1 2 3 4 5 6 7 8 9 10
3)_____	_____	1 2 3 4 5 6 7 8 9 10

Is the condition interfering with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other_____
How long has it been since you felt really good? ☐Days ☐Weeks ☐Months ☐Years ☐ >10 Years

PLEASE CHECK ONE BOX FOR EACH OF THE SYMPTOMS THAT APPLY, USING THIS KEY:

N = Never R = Rarely F = Frequently A = Always

N R F A		N R F A		N R F A	
☐☐☐☐	Headache	☐☐☐☐	Rapid Heart Rate	☐☐☐☐	Swollen Ankles
☐☐☐☐	Facial Pain	☐☐☐☐	High Blood Pressure	☐☐☐☐	Ankle / Foot Pain
☐☐☐☐	Eye Pain	☐☐☐☐	Low Blood Pressure	☐☐☐☐	Tingling if Feet
☐☐☐☐	Blurred Vision	☐☐☐☐	Stomach Pains	☐☐☐☐	Walking Problems
☐☐☐☐	Dizziness	☐☐☐☐	Nausea/Vomiting	☐☐☐☐	Sore Muscles
☐☐☐☐	Earache	☐☐☐☐	Poor Appetite	☐☐☐☐	Weak Muscles
☐☐☐☐	Forgetfulness	☐☐☐☐	Fullness of Bladder	☐☐☐☐	Paralysis
☐☐☐☐	Confusion	☐☐☐☐	Urinary Difficulty	☐☐☐☐	Shakiness
☐☐☐☐	Sinusitis	☐☐☐☐	Frequent Urination	☐☐☐☐	Sweating
☐☐☐☐	Teeth Grinding	☐☐☐☐	Constipation	☐☐☐☐	Insomnia
☐☐☐☐	Dry Mouth	☐☐☐☐	Hemorrhoids	☐☐☐☐	Fainting
☐☐☐☐	Excessive Thirst	☐☐☐☐	Decreased Sex Drive	☐☐☐☐	Convulsions
☐☐☐☐	Unpleasant Taste	☐☐☐☐	Menstrual Irregularities	☐☐☐☐	Irritability/Impatience
☐☐☐☐	Neck Pain	☐☐☐☐	Elbow / Hand Pain	☐☐☐☐	Fatigue/Loss on Energy
☐☐☐☐	Sore Throat	☐☐☐☐	Tingling in Hands	☐☐☐☐	Feel Loss of Control
☐☐☐☐	Lump in Throat	☐☐☐☐	Clammy Hands	☐☐☐☐	Crave Salts
☐☐☐☐	Swallowing Pain	☐☐☐☐	Low Back Pain	☐☐☐☐	Crave Sweets
☐☐☐☐	Unsteady Voice	☐☐☐☐	Hip Pain	☐☐☐☐	Symptoms ? with Stress
☐☐☐☐	Shoulder Pain	☐☐☐☐	Knee Pain	☐☐☐☐	Symp.? with Seasonal Chng
☐☐☐☐	Persistent Cough	☐☐☐☐	Poor Circulation	☐☐☐☐	Unexplained Weight Gain
☐☐☐☐	Chest Pressure	☐☐☐☐	Swollen Joints	☐☐☐☐	Dizziness Upon Standing
☐☐☐☐	Slow Heart Rate	☐☐☐☐	Joint Stiffness	☐☐☐☐	Other_____

ALLERGIES: Please list any Allergies you may have, including medications, foods, seasonal, environmental, etc.
☐None ☐The following:_____

MEDICATIONS: Please list all medications that you are currently taking with the date you began taking them in parenthesis. i.e. Coumadin (May 1998), Celebrex (Jan 2007). ☐None ☐The Following:_____
_____

SCARS / SURGICAL PROCEDURES: List all scars and surgeries: ☐None ☐The Following:_____
_____

SUPPLEMENTS: Do you take Vitamins/Supplements/Herbs/Homeopathics? ☐Y ☐N, If Yes, What are you taking and Who recommended them?_____

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda Pop	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐
Junk Food	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐
Dieting	☐	☐	☐	☐
Relaxation	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	Type	Time
Exercise	☐	☐	☐	_____	_____

	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5hrs	Quality?
Sleep	☐	☐	☐	☐	☐	☐Y ☐N

	5+/day	4/day	3/day	2/day	1/day
Meals	☐	☐	☐	☐	☐

	64+ oz	32-64 oz	16-32 oz	<8 oz
Water	☐	☐	☐	☐

	2+ Hrs	1-2Hrs	30-60 Min	10-30 Min	<10 Min
Cell ph.Use	☐	☐	☐	☐	☐

	4+/day	3/day	2/day	1/day	<1/day
Bowels	☐	☐	☐	☐	☐

Females: Date of last menstrual period_____ Pregnant ☐Y ☐N ☐Maybe Nursing ☐Y ☐N

FAMILY HISTORY: **Check any Conditions that you, or any of your family members have now or have had in the past, that you know of: (G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self. Mark all that apply)**

G	M	F	S	X	
☐	☐	☐	☐	☐	Alcoholism
☐	☐	☐	☐	☐	Anemia
☐	☐	☐	☐	☐	Cancer
☐	☐	☐	☐	☐	Deep Vein Thrombosis
☐	☐	☐	☐	☐	Heart Disease
☐	☐	☐	☐	☐	Diabetes
☐	☐	☐	☐	☐	Diverticulitis/IBS
☐	☐	☐	☐	☐	Eczema
☐	☐	☐	☐	☐	Emphysema
☐	☐	☐	☐	☐	Epilepsy
☐	☐	☐	☐	☐	Goiter
☐	☐	☐	☐	☐	Gout
☐	☐	☐	☐	☐	Hepatitis

G	M	F	S	X	
☐	☐	☐	☐	☐	HIV/AIDS
☐	☐	☐	☐	☐	Miscarriage
☐	☐	☐	☐	☐	Pleurisy
☐	☐	☐	☐	☐	Pneumonia
☐	☐	☐	☐	☐	Rheumatic Fever
☐	☐	☐	☐	☐	Polio
☐	☐	☐	☐	☐	Seizures/Fainting
☐	☐	☐	☐	☐	Stroke
☐	☐	☐	☐	☐	Tumor(s)
☐	☐	☐	☐	☐	Ulcers
☐	☐	☐	☐	☐	Vaccine Reaction
☐	☐	☐	☐	☐	Other:_____

_____

PRIVACY NOTICE:

Patient Health Information:

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any healthcare operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used.

1. The patient understands and agrees to allow Mousseli Chiropractic Corporation of Oxnard to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without written permission.

3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are know by the clinic to assure that your records are not readily available to those who do need them.
6. If a patient has a complaint about the privacy of records please see our office manager or Dr. Mousseli.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse care.

Signatures:

- I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that payment is due at the time services are rendered. I under stand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims and assign all insurance benefits directly to the provider.
- I have read and understand how my patient health information will be used and I agree to these policies.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient's signature _____Date_____

Spouse's or guardian's signature _____Date_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who row or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clink, whether signatories to this form or not,

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

PATIENT SIGNATURE **X** _____ (Date)_____
(Or Patient Representative) (Indicate relationship if signing for patient)

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptor ship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence,

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** _____ (Date) _____
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** _____ (Date) _____