PERSONAL INJURY INTAKE FORM

Today's Date:

Last Name:		**MI:** **First Name:**	
Home Address:		City:	State: Zip:
Date Birth:	Age:	Occupation:	Employer:
Height:	Weight:	Marital Status (Circle): Single, Married, Divorced, Widowed	
Home Phone:		Social Security Number:	
Work Phone:		Cell Number:	

AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have medical payment insurance for the vehicle you were in?	☐ I have, ☐ Someone else has coverage. Indicate the name of the person that the policy is under:
How is this person related to you?	☐ Self, ☐ Parent, ☐ Friend, ☐ Other
Name of your Automobile Insurance Carrier:	
Address of your Automobile Insurance Carrier:	
Claim Adjusters Name/Telephone Number:	Name: Telephone (area code):
Claim Number:	
Do you have an Insurance Deductible?	☐ Yes, ☐ No Deductible is: $
Do you know your Policy Limits for medical bills?	☐ Yes, ☐ No Limit is: $
Have you reported this injury to your insurance carrier?	☐ Yes, ☐ No

☐ Yes, ☐ No. Do you have an attorney representing you? If yes, indicate name, address and telephone of your retained attorney:	Attorney Name: _____ Address: _____ Telephone:

√	I authorize said Doctor to release medical information necessary to process this claim to the above insurance carrier.
√	A photocopy of this authorization shall be considered as valid as the original.
√	I authorize direct payment of medical benefits to the undersigned doctor for services/procedures or supplies described in the billing statement or CMS-1500 form. I authorize said Doctor to use my name in the "Signature on File" in future billings.
√	I authorize use of this form on all my insurance submissions (billings).

You are ultimately responsible for any charges incurred in this office and will be **"balance Billed"** for any amount the insurance carrier(s) does not pay (Excess Payments). It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier.

Patient Signature Date:	I acknowledge that I am ultimately responsible for all charges that are incurred at the doctor's office. I agree to pay for any outstanding bills (including Excess Payments) incurred in this office, as well as paying for co-insurance or deductibles.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) requires that all health care providers comply with patient privacy and security laws (45 CFR 160, 164). Patient confidentiality and privacy/security applies to any **protected health information (PHI).** This notice explains how my protected health information (PHI) may be used and what their office's responsibilities are regarding my privacy rights and protected health information. Indicate whether you are the parent or a legal guardian of the patient or minor. If you want to discuss anything privately that you do not want to be overheard by other persons in the doctor's office, please inform the staff before you see the doctor so a private room can be arranged. Please sign and date below.

Patient Signature and Date:	By signing this form, I acknowledge that this office has presented me with a copy of their HIPAA privacy practices and I have been able to read the practice policies notice that is posted on the waiting room wall.

Doctor's Name/Address: Jeffrey R. Rockenmacher, DC, 4152 Katella Ave., Ste 102, Los Alamitos, CA 90720

Patient Name

1. **The symptom(s) that have prompted me to seek care today include:** _____

_____

2. **And the results of :** ☐ An accident or injury
☐ Work ☐ Auto ☐ Other _____
☐ A worsening long-term problem
☐ An interest in: ☐ Wellness ☐ Other _____

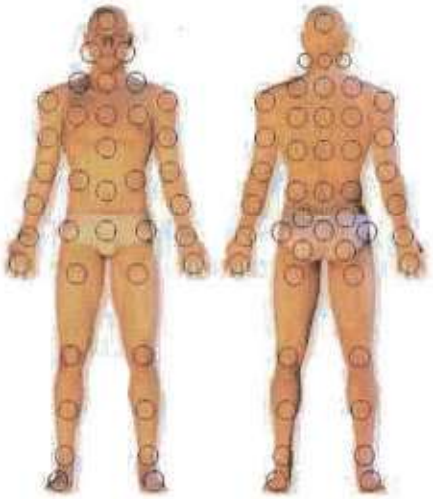
3. **Onset** (When did you first notice your current symptoms?)
_____/_____/_____

4. **Intensity** (How extreme are your current symptoms?)
0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 10
Absent Uncomfortable Agonizing

5. **Duration and Timing** (How often do you feel it?)
☐ Constantly (76-100%)
☐ Frequently (51-75%)
☐ Occasionally (26-50%)
☐ Intermittently (0-25%)

6. **Quality of Symptoms** (What does it feel like?)
☐ Numbness
☐ Tingling
☐ Stiffness
☐ Dull
☐ Aching
☐ Cramps
☐ Nagging
☐ Sharp
☐ Burning
☐ Shooting
☐ Throbbing
☐ Stabbing
☐ Other
_____

7. **Location** (Where does it hurt?) Mark the area(s) on the illustration.



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)
_____

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc?)
What tends to worsen the problem?
_____
What tends to lessen the problem?
_____

10. **Prior Interventions** (What have you done to relieve the symptoms?)
☐ Prescription Medication ☐ Surgery ☐ Ice
☐ Over-the-counter drugs ☐ Acupuncture ☐ Heat
☐ Homeopathic remedies ☐ Chiropractic
☐ Physical Therapy ☐ Massage
☐ Other _____

11. **Have you traveled internationally in the last 6 months? ☐ Yes ☐ No If yes, where?** _____

12. **What else should the doctor know about your current condition?** _____

_____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire your body. Please mark the box beside any conditions that you **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck pain	☐	☐	Back Problems	☐	☐	Hip disorders
☐	☐	Knee injuries	☐	☐	Foot/ ankle pain	☐	☐	Shoulder Problems	☐	☐	Elbow/ wrist pain	☐	☐	TMJ Issues	☐	☐	Poor posture

☐ NONE Initials _____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins & needles	☐	☐	Numbness

☐ NONE Initials _____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High blood pressure	☐	☐	Low blood pressure	☐	☐	High cholesterol	☐	☐	Poor circulation	☐	☐	Angina	☐	☐	Excessive bruising

☐ NONE Initials _____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Shortness of breath	☐	☐	Hay fever	☐	☐	Emphysema	☐	☐	Pneumonia

☐ NONE Initials _____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Ulcer	☐	☐	Anorexia/ Bulimia	☐	☐	Food sensitivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea

☐ NONE Initials _____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Blurred vision	☐	☐	Ringing in ears	☐	☐	Chronic ear infection	☐	☐	Hearing loss	☐	☐	Loss of smell	☐	☐	Loss of taste

☐ NONE Initials _____

Doctor's Initials

Patient Name

g. Integumentary

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐Skin cancer	☐	☐Psoriasis	☐	☐Eczema	☐	☐Acne	☐	☐Hair loss	☐	☐Rash

☐ NONE Initials _____

h. Endocrine

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐Thyroid issues	☐	☐Immune disorder	☐	☐Frequent urination	☐	☐Hypoglycemia	☐	☐Swollen glands	☐	☐Low energy

☐ NONE Initials _____

i. Genitourinary

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐Kidney stones	☐	☐Infertility	☐	☐Erectile dysfunction	☐	☐Prostate issues	☐	☐Bedwetting	☐	☐PMS symptoms

☐ NONE Initials _____

j. Constitutional

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
☐	☐Fainting	☐	☐Low libido	☐	☐Sudden weight change	☐	☐Fatigue	☐	☐Poor appetite	☐	☐Weakness

☐ NONE Initials _____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past of **Have** now.

Had	Have		Had	Have	
☐	☐	AIDS	☐	☐	Tuberculosis
☐	☐	Alcoholism	☐	☐	Typhoid fever
☐	☐	Arteriosclerosis	☐	☐	Ulcer
☐	☐	Cancer	☐	☐	Allergies
☐	☐	Chicken Pox			Food: _____
☐	☐	Diabetes			Medications: _____
☐	☐	Epilepsy			_____
☐	☐	Glaucoma			Environmental: _____
☐	☐	Goiter	☐	☐	Other: _____
☐	☐	Gout			_____
☐	☐	Heart disease			_____
☐	☐	Hepatitis			_____
☐	☐	Malaria			
☐	☐	Measles			
☐	☐	Multiple Sclerosis			
☐	☐	Mumps			
☐	☐	Polio			
☐	☐	Rheumatic Fever			
☐	☐	Scarlet Fever			
☐	☐	Sexually transmitted disease			
☐	☐	Stroke			

15. Operations

Surgical interventions which may or may not have included hospitalizations.

	Date
☐ Appendix Removal	___/___/___
☐ Bypass surgery	___/___/___
☐ Cancer	___/___/___
☐ Cosmetic Surgery	___/___/___
☐ Elective Surgery: _____	___/___/___
☐ Eye Surgery	___/___/___
☐ Hysterectomy	___/___/___
☐ Pacemaker	___/___/___
☐ Spine: _____	___/___/___
☐ Tonsillectomy	___/___/___
☐ Vasectomy	___/___/___
☐ Other: _____	___/___/___
_____	
_____	

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth Control Pills
☐	☐	Blood transfusions
☐	☐	Chemotherapy
☐	☐	Chiropractic care
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone replacement
☐	☐	Inhaler
☐	☐	Massage therapy
☐	☐	Physical therapy
☐	☐	Nutritional supplements:

List _____

_____

_____

☐ ☐ Medications (Prescriptions & Over the Counter)

_____

_____

_____

_____

_____

_____

17. Injuries

Have your ever....

- ☐ Had a fractured or broken bone
  If so, where _____
  when ___/___/___
- ☐ Had spine or nerve disorder
- ☐ Been knocked unconscious
- ☐ Been injured in an accident
  If so, when ___/___/___
- ☐ Used a crutch of other support
- ☐ Used neck or back bracing
- ☐ Received a tattoo
- ☐ Had a body piercing

FAMILY

18. Family History

Some health issues are hereditary. Tell the doctor about the health of your **immediate** family members, e.g. mother, father, sister, brother.

☐ Alzheimer's	☐ Cancer	☐ Diabetes	☐ Hypertension	☐ Thyroid disorder
☐ Arthritis	☐ Depression	☐ Heart disease	☐ Stroke	☐ Other _____

19. Are there any other hereditary health issues that you know about? _____

_____

SOCIAL

20. Social History

Tell the doctor about your health habits and stress levels.

Alcohol use	☐ Daily	☐ Weekly	☐ Never	How much? _____	Prayer or meditation?	☐ Yes	☐ No
Coffee use	☐ Daily	☐ Weekly	☐ Never	How much? _____	Job pressure/stress?	☐ Yes	☐ No
Tobacco use	☐ Daily	☐ Weekly	☐ Never	How much? _____	Financial peace?	☐ Yes	☐ No
Exercising	☐ Daily	☐ Weekly	☐ Never	How much? _____	Vaccinated?	☐ Yes	☐ No
Pain Relievers	☐ Daily	☐ Weekly	☐ Never	How much? _____	Mercury fillings?	☐ Yes	☐ No
Soft drinks	☐ Daily	☐ Weekly	☐ Never	How much? _____	Recreation drugs?	☐ Yes	☐ No
Water intake	☐ Daily	☐ Weekly	☐ Never	How much? _____			

Hobbies: _____

Doctor's Initials

Patient Name

21. Activities of Daily Living

How does this condition interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	☐	☐	☐	☐	Grocery shopping	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐	Household chores	☐	☐	☐	☐
Standing	☐	☐	☐	☐	Lifting objects	☐	☐	☐	☐
Walking	☐	☐	☐	☐	Reaching overhead	☐	☐	☐	☐
Lying down	☐	☐	☐	☐	Showering or bathing	☐	☐	☐	☐
Bending over	☐	☐	☐	☐	Dressing myself	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	Love life	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐	Getting to sleep	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐	Staying asleep	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐	Concentrating	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐	Exercising	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐	Yardwork	☐	☐	☐	☐

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? ____ Hours

24. What is the **type** and **approximate age** of your mattress and pillow?

_____

25. What is your preferred sleeping position?

_____

26. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

27. What would be the most significant thing you could do to improve your health? _____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement

_____ Initials **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

_____ Initials **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

_____ Initials **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of late menstrual period (MM/DD/YYYY): _____**

_____ Initials **I grant permission to be called to confirm or reschedule an appointment and be sent occasional cards, letters, emails or health information to me as an extension of my care of this office.**

_____ Initials **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any non-covered services I receive.**

_____ Initials **To best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity of cause of my health concern.**

If patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Doctor's Initials

PEDESTRIAN COLLISION EVENT

PATIENT INFORMATION

Patient Name: _____ Date:
Address: _____ City _____ Zip _____
Home Telephone: _____ Work Telephone: _____
Date of Birth: _____ Social Security No: _____
Date of injury: _____ Time of injury: _____ ☐ AM ☐ PM
City where pedestrian injury occurred: _____
Street (location) where injury occurred: _____

☐ Yes, ☐ No Did the police come to the collision scene and make a report?
☐ Yes, ☐ No Were you cited by the police? If yes, name of officer: _____
☐ Yes, ☐ No Is an attorney currently representing you? Name/address/phone: _____

DESCRIBE HOW THE PEDESTRIAN INJURY HAPPENED:

INDICATE (CHECK) STREET/CROSSWALK ENVIRONMENT YOU WERE IN:

☐	In marked crosswalk with stop signs
☐	In marked crosswalk with lighted pedestrian signs
☐	In unmarked area of the street. Injury did not occur in marked crosswalk area
☐	Other

AT THE TIME OF IMPACT YOU WERE:

☐ Walking	☐ Running/Jogging
☐ Stopped	☐ Other

DESCRIPTION OF VEHICLE/PERSON/OBJECT THAT HIT YOU OR THAT YOU HIT:

☐ Passenger car	☐ Motorcycle	☐ Bus
☐ Sports Utility Vehicle	☐ Bicycle	☐ Semi-truck
☐ Pick-up Truck	☐ Large truck	☐ Other

POSTED SPEED LIMIT IN IMPACT AREA (If uncertain check the unknown box):

WHAT IS THE SPEED LIMIT POSTED IN THE AREA WHERE THE INJURY OCCURRED?
_____ MPH. ☐ Unknown

Doctor's Name/Address: Jeffrey R. Rockenmacher, DC, 4152 Katella Avenue, Suite 102, Los Alamitos, CA 90720

PEDESTRIAN COLLISION (Page 2)

AT THE TIME OF IMPACT THE VEHICLE/PERSON THAT HIT YOU WAS:

☐	Slowing down	☐	Gaining Speed
☐	Braking. You heard the brakes.	☐	Moving at steady speed

DURING AND AFTER THE IMPACT, DID YOUR BODY:

☐	Stay upright, not falling down	☐	Flip upwards onto the hood or roof of the car
☐	Fall down hitting street or sidewalk	☐	Slide along street or sidewalk
☐	Got hit by another vehicle	☐	Slide under the striking vehicle
☐	Flip end-over-end in front of the vehicle	☐	Other

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines and match the left side to the right side.

Head	Front Windshield
Face	Front Bumper
Shoulder	Light Fixtures
Arm/hand	Front grill of vehicle
Front chest wall	Hood of car
Side chest wall	Pavement/Street Surface
Hip/abdomen	Frame of car near windows
Knee	Roof of other vehicle
Leg	Other
Foot	Other

CHECK IF ANY OF THE PARTS BROKE, BENT, OR WERE DAMAGED IN THE VEHICLE THAT HIT YOU:

☐	Front Bumper	☐	Front Windshield
☐	Front Hood	☐	Roof of vehicle
☐	Front Grill	☐	Unknown

* If your body was thrown or slid after the impact, estimate how many feet you slid or were thrown?
_____ feet. **If unknown, write in "unknown."**

Patient Name:	Date:	Doctor: Jeffrey R. Rockenmacher, DC 4152 Katella Avenue, Suite 102 Los Alamitos, CA 90720

Form 4120

EMERGENCY ROOM, DISABILITY, & CURRENT TREATMENT (Page 4)

YES	NO	EMERGENCY ROOM
☐	☐	Did you go to the emergency room afterward? If no, go to the bottom of this form and fill out the disability/treatment sections. If yes, indicate when date and time: _____ Name of the emergency room? City:
☐	☐	Did you go to emergency room in an ambulance?
☐	☐	Did you or another person drive you to emergency room? Name of other person:
☐	☐	Were you hospitalized after being seen in the Emergency Room? If yes, how many days:
☐	☐	Did the emergency room doctor take **X-Rays**? Check what regions x-rays were taken: ☐ Skull/Face x-rays ☐ Rib/Chest x-rays ☐ Neck or Middle back x-rays ☐ Collar bone x-rays ☐ Low back or Hip/Pelvis x-rays ☐ Shoulder, Arm or Hand x-rays ☐ Leg or Foot ☐ Other
☐	☐	Did the hospital or clinic take **MRI or CT SCAN** of your body? If yes, indicate what areas of body: ☐ Skull, ☐ Neck, ☐ Low back or hip/pelvis, ☐ Other
☐	☐	Did you have any broken bones/fractures? If yes, where:
☐	☐	Did you have a splint or cast put on for any sprain or fracture? If yes, type/location:
☐	☐	Did you have any dislocations? If yes, where:
☐	☐	Did you have **any cuts, lacerations, or abrasions**? If yes, where:
☐	☐	Did you require any stitching for cuts? If yes, where:
☐	☐	Did you have any **visible bruises or lumps**? If yes, where:
☐	☐	Did you have any visible **bruises a**long the shoulder or lap portions of your **seatbelt?**
☐	☐	Did the emergency room doctor give you pain medications or muscle relaxants?
☐	☐	Did the emergency room doctor give you any other medications/prescriptions?
☐	☐	Did you require any surgery after the accident? If yes, describe type and date:
☐	☐	Were you hospitalized overnight? If yes, indicate dates hospitalized:

What did the Emergency Room or Hospital Doctor(s) say was wrong with you?

DISABILITY-HAVE YOU BEEN UNABLE TO WORK SINCE INJURY?

☐ **YES,** ☐ **NO I have lost days (time) off work?** If yes, check if you were off work: ☐ Partially ☐ Completely

Please list all dates off work: From _____ to _____.

If yes, what physical activities (sitting, bending, lifting, walking, etc) have limited your ability to work?

CURRENT TREATMENT

☐ YES, ☐ NO Are you currently seeing any other doctor/therapist? If yes, who: _____

☐ YES, ☐ NO Are you currently using any type of brace, support, collar, cane, crutches, TENS unit, or other devices to help your pain since the injury? If yes, indicate what type and how often you use: _____

☐ YES, ☐ NO Are you currently taking any over-the-counter or prescribed medications to help your pain? If yes, list these medications and how often you take them: _____

☐ YES, ☐ NO Have you been treating yourself (ice, heat, lotions, etc.)? If yes, list: _____

PROVIDERS SEEN SINCE THE COLLISION (Page 5)

Start with the first hospital/clinic/doctor/therapist that you went to after your motor vehicle crash and list all health care providers (all types of doctors or therapists), up to your last health care provider seen, and check all that apply for each. Be certain to list these in sequence from first health care provider seen to the last one.

① Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____ Date _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
☐ X-ray of chest/ribs/middle back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back/ pelvis/hips	☐ Muscle stimulation	☐ Neck collar (brace)
☐ X-ray of shoulder/arms/legs	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse

② Name hospital/doctor/therapist/center seen: _____

Address: _____ Date _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
☐ X-ray of chest/ribs/middle back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back/pelvis/hips	☐ Muscle stimulation	☐ Neck collar (brace)
☐ X-ray of shoulder/arm/leg	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests: _____	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse

③ Name of hospital/doctor/therapist/center: _____

Address: _____ Date _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
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☐ X-ray of shoulder/arm/leg	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests: _____	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse

HEADACHE/MIGRAINE/HEAD/FACE PAIN AND/OR INJURY HISTORY (Page 3)

Please print clearly. Check all boxes that apply to you and describe your "YES" responses. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

YES	NO	GENERAL PRIOR HEAD REGION HISTORY
☐	☐	Have you recently had a fever, chill, respiratory or other infection, rash, circulatory disorder, or joint pain/swelling?
☐	☐	Have you had any illness or disease involving your muscles, collagen, blood, blood vessels, skin, or nerves?
☐	☐	Have you been told that you have an autoimmune or genetic condition of the head, brain or spine/spinal cord?
☐	☐	Have you been told you have arthritic, neurological, or vascular disease in your body or head/brain areas?
☐	☐	Have you had a previous head injury, blow or fall, striking your head, or concussion in the past?
☐	☐	Have you ever had a disease or disorder to the skull, blood vessels, brain, eyes, or spinal cord? Describe below.
☐	☐	Have you been told that you have ever had a stroke, blood clot, artery blockage, or Trans-Ischemic Attack (TIA)?
☐	☐	Recently, have you had blurry or double vision, trouble speaking/swallowing, dizziness, fainting spells, nausea, trouble walking or balance problems, or hand/feet numbness or weakness? Describe below.
☐	☐	In the past four weeks has your head/neck been exposed to any violent motion/jerking or force? Describe below.

If yes, describe and provide dates:

If you have ever had headaches or migraines in the past, would you describe the type and severity of your current head pain/symptoms as being similar to the head pain you have had in the past, better than usual, slightly worse than usual, or a type of head pain that is entirely new or unusually severe? Describe below.

Patient: Describe any condition, accident, activity, medication, posture, diet, stress, etc., that may have caused or contributed for your current head pain/symptoms:
☐ No ☐ Yes. Have you had a history of having prior headaches/migraines/head/face pain/symptoms in the 12 months before this motor vehicle collision? If yes, describe their frequency and severity?

HEAD PAIN/SYMPTOM DESCRIPTION

Describe your head pain location (top head, forehead, eye area, left side, right side, both sides, or back of your head).	
When did your head pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe all head/neck injuries and what happened.	
Describe all aggravating physical activities/motions. What makes your head pain worse?	
Describe any relieving physical activities. What activities lessen your head symptoms?	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, worst pain ever, etc).	
Describe any symptoms that originate from your neck or jaw region that radiate to your head.	
How frequent and severe are your pain/symptoms?	Percent of time _____ %. Pain Severity (0-10) _____
List all prior doctors you have seen for your headaches/head pain before, describe any treatment/medications used, and describe the name or types of headaches/migraines that doctors have diagnosed you as having.	

NECK, BACK, HIP, PELVIS PAIN AND/OR INJURY HISTORY (Page 3)

Please print clearly. Check all boxes that apply to you and describe your "YES" responses. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

YES	NO	GENERAL SPINE HISTORY (HEAD, NECK, MIDDDLE-LOW BACK, SACRUM, AND PELVIS)
☐	☐	Have you been told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?
☐	☐	Told that you have a bulging/herniated disc or disc degeneration in the spine?
☐	☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis in your spine or joints?
☐	☐	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?
☐	☐	Have you had a previous head injury or brain/spinal cord disease in the past?
☐	☐	Have you injured your neck, back, sacrum or pelvis in the past?
☐	☐	Have you ever had an injection into your discs or spine (facet joints) in your back, sacrum or neck?
☐	☐	Do you have a stomach, intestinal, digestive, malabsorption disorder (wheat allergy, etc.), muscle disease, prostate, ovarian, or uterine problem, condition or disease that could be affecting your back?

If yes, describe and provide dates:

SYMPTOM OR COMPLAINT ONSET

☐ Suddenly, ☐ Gradually. Check box indicating if your current neck/back symptoms developed gradually or suddenly.

NECK PAIN AND/OR INJURY HISTORY

Describe your neck pain location (left side, right side, middle of your neck, both sides, front, or back).	
When did your neck pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe what happened.	
Describe all aggravating physical activities/motions. What makes your neck or referring arm pain worse?	
Describe any relieving physical activities. What activities lessen your neck/arm symptoms?	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff).	
Describe any symptoms that originate from your neck that radiate to your head/shoulders/arms/hands.	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your neck before.	

YES	NO	NECK REGION HISTORY CONTINUED
☐	☐	Do you get dizzy when you look up or twist your head? If yes, how often:
☐	☐	Do you black out, lose your balance or get a headache when you look up or twist your head?
☐	☐	Do you feel your neck pain sends pain downwards between your shoulders or to the front of your chest?
☐	☐	Have you had a new type of headache or an unusually severe headache recently?
☐	☐	Have you noticed your head leaning or tilting to one side recently?

UPPER-MIDDLE BACK, LOW BACK, PELVIS REGION HISTORY (Page 4)

(Skip this page if you do not have any injuries or symptoms here)

Describe your pain location (middle back, lower back, sacrum and if located in the front/side/back of body)	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe what happened.	
Describe all aggravating physical activities/motions. What makes your back or referring leg pain worse?	
Describe any relieving physical activities. What activities lessen your back or leg symptoms?	
Describe any symptoms that originate from your back that radiate to your chest, hips, legs, or feet.	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your back before.	

YES	NO	THORACIC AND LOW BACK REGION HISTORY CONTINUED
☐	☐	Do you have pain that shoots or radiates outward along your rib cage?
☐	☐	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
☐	☐	Do you have a tight band-like feeling sometimes around your chest?
☐	☐	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
☐	☐	When you move your neck around, does your middle back pain or chest pain increase?
☐	☐	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
☐	☐	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distance that is relieved by resting or sitting down? This pain resumes after walking for same distance.
☐	☐	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting.
☐	☐	Does either leg or foot drag on the floor when you walk?
☐	☐	Do you have a lot of leg cramps at night recently?
☐	☐	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
☐	☐	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
☐	☐	Have you recently noticed that either of your legs occasionally gives out on you when you walk?
☐	☐	Does one or both of your legs feel weak recently?
☐	☐	Has your anal-rectal region been completely numb recently?

Please print clearly

If yes, describe and indicate dates:

EXTREMITY PAIN OR INJURY QUESTIONNAIRE

Answer the following questions if you have extremity symptoms or injury. Skip this page if you do not. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with. Please print clearly.

SHOULDER, ARM, ELBOW, WRIST AND HAND REGION

Describe pain location (left, right, middle, front, back, top). Example: top of shoulder joint/inside left elbow)	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe what happened.	
Describe all aggravating physical activities/motions. What makes your shoulder-arm symptoms worse?	
Describe any relieving physical activities/motions. What lessens your shoulder-arm pain-symptoms?	
If present, describe which fingers or part of your hand you have any pain, numbness, or tingling.	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff).	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your shoulder, arm, or hands before.	

HIP, LEG, KNEE, ANKLE AND FOOT REGION

Describe your pain location (left, right, middle, front, back). Example: front of hip/outer calf area.	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe what happened.	
Describe all aggravating physical activities/motions: What makes your hip-leg pain-symptoms worse?	
Describe any relieving physical activities: What lessens your hip-leg symptoms-pain?	
If present, describe which toes or part of your leg/foot you have any pain, numbness, or tingling.	
Describe how your symptoms feel (examples: dull, sharp, ache, numbness/tingling, stiff, etc).	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen for your hip, leg, knee, ankle, and foot before.	

☐ No, ☐ Yes. **HAVE YOU HAD ANY PRIOR INJURIES OR FRACTURES TO YOUR ARMS AND LEGS?**

Describe body part, date, and residual pain:

Patient Name:	Date:	Doctor: Jeffrey R. Rockenmacher, DC

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

PATIENT INSTRUCTIONS: *Look at each symptom listed in the left column and* ***make a single check mark or several check marks in the appropriate columns*** *to the right for the specific symptoms which apply to you relative to the onset and current complaints. Leave the row blank if the symptom listed below does not apply to you.*

SYMPTOM LIST (Check all of the symptoms that began after your injury that apply to you)	**BEGAN IN LESS THAN 24 HOURS AFTER INJURY**	**SYMPTOMS BEGAN 1 TO 7 DAYS AFTER INJURY**	**YOU HAVE SYMPTOMS PRESENTLY**	**YOU HAD SIMILAR SYMPTOMS WITHIN 12-MONTHS PRIOR TO THIS INJURY**
Headache/migraine/face pain				
Nausea and/or vomiting				
Tinnitus (ear ringing)				
Blurry vision or other visual symptoms				
Memory problems or forgetful				
Poor concentration or less mental stamina				
Dizziness or giddiness				
Feel unsteady on feet when it is dark at night				
Balance problems when reaching overhead				
Loss of coordination with arms/hands/legs				
Feel unsteady when walking				
Misjudges distance when moving about				
Feel unsteady bending down to pick-up items				
Tripping while walking since injury				
Light-headed when turning head-looking up				
Feel unsteady when standing up/sitting down				
Sensitivity to light or sound				
Fatigue since injury				
Loss or absence of smell and/or taste				
Pain/difficulty swallowing				
Jaw pain/soreness or difficulty chewing				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm/hand pain/tingling/numbness				
Weakness in arms or hands				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Weakness in legs or feet				
Pain radiating down leg(s)				
Knee, lower leg or calf pain				
Ankle/foot/toe pain				
Other				

Jeffrey R. Rockenmacher, DC, 4152 Katella Avenue, Suite 102, Los Alamitos, CA 90720

GENERAL HEALTH HISTORY (Page 1)

DESCRIBE ALL OF THE REASON(S) WHY YOU HAVE COME TO OUR OFFICE (Symptoms/Injury). Print Clearly

Check no or yes to the questions below. If yes, check if you had it recently or had the condition in the past?

NO	YES	GENERAL QUESTIONS
☐	☐	Do you have a history of poor healing or told that you have a healing disorder?
☐	☐	Do you smoke cigarettes or use tobacco products recently or currrently?
☐	☐	Do you have a thyroid, kidney, liver/gallbladder, or other endocrine-metabolic disorder?
☐	☐	Have you been told you are pre-diabetic (hypoglycemia), diabetic or have high cholesterol?
☐	☐	Have you had a heart attack, heart disease, a heart pacemaker or a neck or chest shunt?
☐	☐	Do you have any infectious diseases such as AIDS, Tuberculosis, Meningitis, Hepatitis, etc.?
☐	☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?
☐	☐	Do you have problems with dizziness, blacking out, balance problems, fainting, or tripping?
☐	☐	Do you have an epilepsy-seizure-Convulsion history or any other neurological disease?
☐	☐	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?
☐	☐	Have you been diagnosed with cancer or had cancer treatment or surgery of any type?
☐	☐	Have you had a stroke or transient ischemic attacks (TIA).
☐	☐	Have you had blood clots, bleeding or vascular disorders, or told you have an abdominal or brain aneurysm?
☐	☐	Do you have hypertension or high blood pressure? If yes, name of MD currently seeing:
☐	☐	Do you have an autoimmune disease, digestive or intestinal disease, or respiratory diseases, etc?
☐	☐	Do you have a history of fatigue, weight loss/gain, fever, kidney/ovarian pain, or bowel/bladder disorders
☐	☐	**Women only**: Check box to left if there any chance that you are currently pregnant

If you checked yes above, please describe:

HAVE YOU HAD PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN?

☐ **NO,** ☐ **YES. (Check NO box if you have never had a history in the past)** If yes, please describe below:

HAVE YOU HAD FRACTURES/BROKEN BONES IN THE PAST?

☐ **NO,** ☐ **YES. (Check NO box if you have never had any broken bones in the past).** If yes, please describe below:

HAVE YOU EVER BEEN HOSPITALIZED?

☐ **NO,** ☐ **YES. (Check NO box if you have never been hospitalized in the past)** If yes, please describe below:

HAVE YOU HAD ANY PREVIOUS SURGERIES?

☐ **NO,** ☐ **YES. (Check NO box if you never had any surgical procedure in the past).** If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen), please describe type and when:

Patient Name:	Date:	Doctor: Jeffrey R. Rockenmacher, DC

GENERAL HEALTH HISTORY (Page 2)

PRIOR INTERVENTION BY OTHER HEALTH CARE PROVIDERS

☐ No, ☐ Yes. **Have you seen any other doctors for the same condition(s) that you are seeking chiropractic today?**

If yes, list doctor names, tests, and results:

☐ No, ☐ Yes. **Have you taken any pain or anti-inflammatory medications today?** If yes, describe the name(s) of the medication(s) and when you took it last: _____

☐ No, ☐ Yes. **Do you have a fever, cold, virus, or infection currently?** If yes, describe: _____

☐ No, ☐ Yes. **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, rheumatoid arthritis, other forms of joint or spine arthritis, herniated discs in the spine, spinal cord disease, brain disease, nerve disease, blood vessel aneurysms, blood disease, or other diseases?

If yes, please describe:

☐ No, ☐ Yes. **Have you been treated by a Chiropractor for any condition and/or injury in the past?**
List Chiropractor's Name: _____ City: _____ Year: _____
List Problem(s) that the Chiropractor treated you for: _____

Please list the name of your primary medical doctor and when you had your last appointment?	

☐ No, ☐ Yes. **Do you have any problems laying face down on an examination table** (tender breasts, chest or breast surgical implants, ports, etc? If yes, why: _____

SLEEPING PATTERNS AND/OR DISORDERS

☐ No, ☐ Yes. **Do you sleep normally at night?** In no, please describe your sleeping problems below:

MEDICATION HISTORY (PRESCRIBED AND OVER-THE-COUNTER)

☐ No, ☐ Yes. **Are you taking any medications currently?** In yes, list all medications that you are taking:

FOOD OR MEDICATION ALLERGY HISTORY

☐ No, ☐ Yes. Do you have allergies to any medications, foods, shellfish, seafood, etc? If yes, List:

EXERCISE ROUTINE

☐ No, ☐ Yes. **Do you exercise every week?** If yes, describe your typical routine over the past month.

Oswestry Disability Index

Name: _____ **Date:** _____ **Score:** _____

PLEASE READ: Please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section***. Mark **ONE** box only in each section that most closely describes you ***today***.

Section 1 – Pain Intensity

A. ☐ I have no pain at the moment
B. ☐ The pain is very mild at the moment
C. ☐ The pain is moderate at the moment
D. ☐ The pain is fairly severe at the moment
E. ☐ The pain is very severe at the moment
F. ☐ The pain is the worst imaginable at the moment

Section 2 – Personal Care (washing, dressing, etc.)

A. ☐ I can look after myself normally without causing extra pain
B. ☐ I can look after myself normally but it is very painful
C. ☐ It is painful to look after myself and I am slow and careful
D. ☐ I need some help but manage most of my personal care
E. ☐ I need help every day in most aspects of self care
F. ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting

A. ☐ I can lift heavy weights without extra pain
B. ☐ I can lift heavy weights, but it causes extra pain
C. ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
D. ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. ☐ I can only lift very light weights, at the most
F. ☐ I cannot lift or carry anything at all

Section 4 – Walking

A. ☐ Pain does not prevent me from walking any distance
B. ☐ Pain prevents me from walking more than one mile
C. ☐ Pain prevents me from walking more than ¼ mile
D. ☐ Pain prevents me from walking more than 100 yards
E. ☐ I can only walk while using a stick or crutches
F. ☐ I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting

A. ☐ I can sit in any chair as long as I like
B. ☐ I can only sit in my favorite chair as long as I like
C. ☐ Pain prevents me from sitting more than 1 hour
D. ☐ Pain prevents me from sitting more than ½ hour.
E. ☐ Pain prevents me from sitting more than ten minutes
F. ☐ Pain prevents me from sitting at all

Section 6 – Standing

A. ☐ I can stand as long as I want without extra pain
B. ☐ I can stand as long as I want but gives me extra pain
C. ☐ Pain prevents me from standing for more than 1 hour
D. ☐ Pain prevents me from standing more than ½ hour
E. ☐ Pain prevents me from standing for more than 10 minutes
F. ☐ Pain prevents me from standing at all

Section 7 – Sleeping

A. ☐ My sleep is never disturbed by pain
B. ☐ My sleep is occasionally disturbed by pain
C. ☐ Because of pain I have less than 6 hours' sleep
D. ☐ Because of pain I have less than 4 hours' sleep
E. ☐ Because of pain I have less than 2 hours' sleep
F. ☐ Pain prevent me from sleeping at all

Section 8 – Social Life

A. ☐ My social life is normal and causes me no extra pain
B. ☐ My social life is normal, but increases the degree of pain
C. ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sports, etc.
D. ☐ Pain has restricted my social life and I do not go out as often.
E. ☐ Pain has restricted my social life to my home
F. ☐ I have no social life because of the pain

Section 9 – Traveling

A. ☐ I can travel anywhere without pain
B. ☐ I can travel anywhere but it gives me extra pain
C. ☐ Pain is bad but I manage journeys over 2 hours
D. ☐ Pain restricts me to journeys of less than 1 hour
E. ☐ Pain restricts me to short necessary journeys under 30 minutes
F. ☐ Pain prevents me from traveling except to receive treatment

Section 10 – Employment/ Homemaking

A. ☐ My normal homemaking/job activities do no cause pain
B. ☐ My normal homemaking/job activities increase my pain, but I can still perform these tasks.
C. ☐ I can perform most of my homemaking/job activities, except for more physically stressful activities
D. ☐ Pain prevents me from doing anything but light duties
E. ☐ Pain prevents me from doing even light duties
F. ☐ Pain prevents me from performing any job or homemaking chores.

COMMENTS: _____

ROCKENMACHER
CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

Rockenmacher Chiropractic Financial Agreement for Personal Injury Patients

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

PARTY RESPONSIBLE:
If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your insurance policy to cover treatment charges incurred in our office.

MEDPAY: If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.
PIP: If you were a passenger in another vehicle, and your own car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.
3rd PARTY: If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above or beyond your total bill in this office will be refunded to you.

ATTORNEY LIENS:
If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any undid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT:
As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment for these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please, don't hesitate to ask.

I have read and agree to the above

_____ _____

Patient's Signature Date

ROCKENMACHER

CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, these are certain complications which may arise during Chiropractic adjustment. Those complications include, but are not limited to; fracture, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertabral 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 procedures which the doctor feels at the time, based on the facts then know, are in my best interest.

I have had an opportunity to discuss with the doctor named below 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 have read or have had read to me the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighted the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for present condition and or any future conditions for which I seek treatment.

Print name (s) of Doctor Treating This Patient

Jeffrey R. Rockenmacher, D.C.

4152 Katella Ave, Ste #102

Los Alamitos, CA 90720

DO NOT SIGN UNTIL HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient	Date
Signature of Patient	Date
Signature of Patient's Representative	Date
Witness to Patient's Signature	Date
Translated by	Date

Office (562) 598-9609 • Fax (562) 799-1462

4152 KATELLA AVE., SUITE 102 • LOS ALAMITOS, CA 90720

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HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

**Notice of Privacy Practices can be obtained at http://rockenmacherchiropractic.com/new-patient-center/notice-of-privacy-practice.html or you can request a hard copy from our front desk.*

You may refuse to sign this acknowledgement. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please ***print*** name of Patient | Patient ***signature*** / If Guardian please sign

_____ _____

Please print name of Legal Representative/Guardian | Relationship of Legal Representative / Guardian

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because _____

Other (please describe) _____

Signature of Privacy Officer

_____

ROCKENMACHER
CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth:_____ **Date of Request:** _____

As required by HIPPA Privacy Regulations, protected health information may not be used or disclosed to a third party without patient authorization.

I hereby authorize Dr. Jeffrey Rockenmacher and his employees to disclose my Patient Health Information to the following person, health care provider or other:

1. **Health Insurance Payer(s):** _____
2. **Family Member(s):** _____

Patient health information authorized to be disclosed:

1. Patient intake forms, chart notes, patient records, Dr's reports, diagnostic studies, diagnosis, prognosis, appointments, balances.

2. Other: _____

For the specific purpose of:

1. Processing of claims, obtaining authorization for treatment, scheduling appointments, collecting balances, and obtaining patient information to facilitate healthcare operations.

2. Other: _____

Effective dates for this authorization: **1/1/2021** through **12/31/2021**. This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect his office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information.

_____ _____

Signature of Patient or Patient's Authorized Representative ***Date***

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NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Accident: _____

I do hereby authorize _____ to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____

DATED PATIENT'S SIGNATURE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that tin the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

DATED ATTORNEY SIGNATURE

ROCKENMACHER
CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

PATIENT: _____

INSUREDL _____

DATE OF INJURY: _____

CLAIM#/POLICY#: _____

SOCIAL SECURITY#: _____

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician listed below:

Rockenmacher Chiropractic Inc.
4152 Katella Avenue, Ste #102
Los Alamitos, CA 90720
Tel (562) 598-9609 Fax (562) 799-1462

As owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bill for the remainder of this claim.

Thank you for your cooperation in this matter.

_____ _____

Patient/Insured Signature Date

ROCKENMACHER
CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

Rockenmacher Chiropractic Consent to Treat a Minor

I, undersigned parent/guardian having legal custody/legal guardianship of _____, a minor, do hereby authorize _____ to perform x-rays
(Name of minor) (Provider)
Examination and provide any chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor in the state of California.

It is understood that this authorization is given prior to any specific diagnosis or treatment being required, but is given to provide authority to give specific consent to any and all such diagnosis and treatment which _____, meeting the requires of this
(Provider)
authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain in effect until _____ is 18 years of age, or the authorization is revoked in writing
(Name of minor)

Signature of Parent/Legal Guardian: _____

Printed Name of Parent/Legal Guardian: _____

Relationship to Patient: _____

Date: _____

Office (562) 598-9609 • Fax (562) 799-1462
4152 KATELLA AVE., SUITE 102 • LOS ALAMITOS, CA 90720