CONFIDENTIAL
HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential.
We comply with all federal privacy standards. Please print clearly.

ROCKENMACHER
CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Whom may we thank for referring you?

☐ No ☐ Yes **When?** _____

If so, whom?

Your Last Name

Gender
☐ Male ☐ Female

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Address

City **State/Province** **ZIP/Postal Code** **Home Phone** **Spouse's Name**

Email Address **Cell Phone** **Child's Name and Age**

Emergency Contact **Phone** **Child's Name and Age**

Your Occupation **Child's Name and Age**

Your Employer

May we contact you at work?

☐ Yes ☐ No

Address

City **State/Province** **ZIP/Postal Code** **Work Phone**

Insurance Carrier **Policy Number** **Primary Care Provider's Name**

Insured's Last Name

First Name **Middle Name (or Initial)**

Who carries this policy?
☐ Self ☐ Spouse ☐ Parent

Insured's Employer

Address

State/Province **ZIP/Postal Code** **Employer's Phone**

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?)

   _____/_____/_____

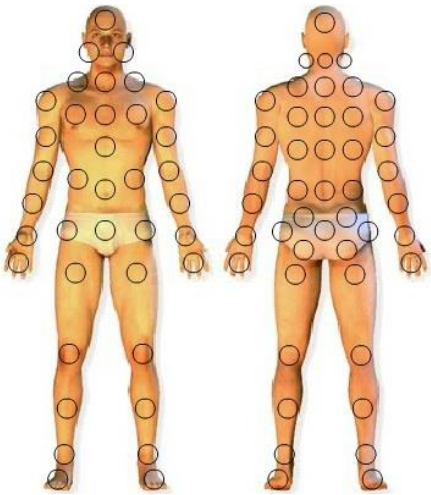
4. **Intensity** (How extreme are your current symptoms?)

   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** _____

_____
Patient Name

_____
Doctor's Initials

Patient Name _____

g. Integumemtary

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	
☐	☐	AIDS
☐	☐	Alcoholism
☐	☐	Arteriosclerosis
☐	☐	Cancer
☐	☐	Chicken Pox
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Goiter
☐	☐	Gout
☐	☐	Heart disease
☐	☐	Hepatitis
☐	☐	Malaria
☐	☐	Measles
☐	☐	Multiple Sclerosis
☐	☐	Mumps
☐	☐	Polio
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Sexually transmitted disease
☐	☐	Stroke

Had	Have	
☐	☐	Tuberculosis
☐	☐	Typhoid fever
☐	☐	Ulcer
☐	☐	Allergies

Food: _____
Medications: _____
_____
Environmental: _____

☐ ☐ Other: _____
_____
_____
_____

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? _____
Coffee use	☐ Daily	☐ Weekly	☐Never	How much? _____
Tobacco use	☐ Daily	☐ Weekly	☐Never	How much? _____
Exercising	☐ Daily	☐ Weekly	☐Never	How much? _____
Pain Relievers	☐ Daily	☐ Weekly	☐Never	How much? _____
Soft drinks	☐ Daily	☐ Weekly	☐Never	How much? _____
Water intake	☐ Daily	☐ Weekly	☐Never	How much? _____

Hobbies:_____

Prayer or meditation?	☐ Yes	☐ No
Job pressure/stress?	☐ Yes	☐ No
Financial peace?	☐ Yes	☐ No
Vaccinated?	☐ Yes	☐ No
Mercury fillings?	☐ Yes	☐ No
Recreation drugs?	☐ Yes	☐ No

_____
Doctor's Initials

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)

_____ **Patient Name**

_____ **Doctor's Initials**

ROCKENMACHER
CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

Rockenmacher Chiropractic Financial Agreement for TriWest Healthcare Alliance Patients

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled.

If you are a veteran and covered under TriWest Healthcare Alliance, all fees for health care services will be paid by TriWest Healthcare Alliance provided the following:

1. You must contact your VA Medical Center in order to authorize chiropractic care and to schedule your initial visit at our office.

2. The VA authorizes a specified number of visits within a 90-day date range.

3. Additional visits beyond the authorized amount need to be approved by the VA Medical Center before continuing chiropractic treatment.

If you have any questions at any time, please feel free to ask.

I have read and agree to above.

_____	_____	_____
Patient Name	Patient Signature	Date

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

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

ROCKENMACHER
CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

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***