6370 Lusk Blvd. Ste. F205, San Diego, CA
www.SDSpinalCare.com
(858) 877-3217

San Diego Spinal Care

Dr. Aaron A. Kenna, DC
Upper Cervical Specific Chiropractor

Confidential Health Record

Today's Date M/D/Y ___/___/___

Welcome To Our Office

Whom may we thank for referring you to our office? PLEASE CHECK & COMPLETE.

○ Medical Doctor _____ ○ Family _____ ○ Friend _____

○ Internet/Website _____ ○ Other _____

Personal Information

Name LAST _____ FIRST _____ MIDDLE _____

Birth Date M/D/Y ___/___/___ Age _____ Sex PLEASE CHECK ○ Male ○ Female Medicare # _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone # HOME _____ CELL _____ WORK _____

Email Address _____

Marital Status PLEASE CHECK ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated

Spouses Name LAST _____ FIRST _____

Emergency Contact

Name LAST _____ FIRST _____ Relationship ○ Spouse ○ Relative ○ Friend

Phone # HOME _____ CELL _____ WORK _____

Medical Contact

Medical Doctor Name _____ Specialty _____ Phone # _____

City _____ State _____

Employment Information

Occupation/Job Title _____

Business name _____

Work _____ # hours/day City _____ State _____

Present Health Challenges

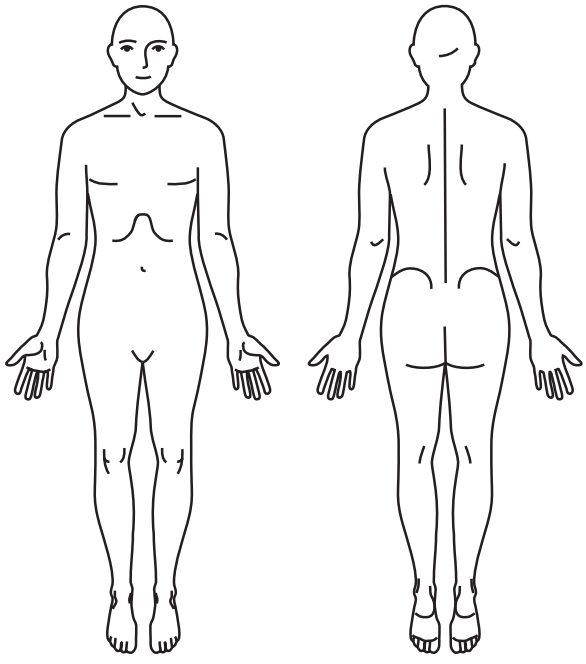
IF YOU ARE HERE FOR **WELLNESS SERVICES** AND HAVE NO SYMPTOMS OR COMPLAINTS, CHECK HERE ○

Explain why you are here today _____

When did these problems originally start? _____

Has it ever occurred before? ○ Yes ○ No

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



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Confidential Health Record 2/4

PLEASE CHECK THE APPROPRIATE CIRCLE & COMPLETE BLANKS.

Body Area(s) Involved ○ Neck ○ Back ○ Head ○ Other _____

Mechanism of Onset ○ Auto ○ Work ○ Slip/Fall ○ Lifting ○ Slept Wrong ○ Repetitive Motion ○ Other _____

Current Symptoms ○ Pain ○ Numbness ○ Stiffness ○ Weakness ○ Other _____

Quality ○ Burning ○ Diffuse ○ Dull/Aching ○ Localized ○ Radiating ○ Sharp ○ Shooting ○ Stabbing ○ Throbbing ○ Tightness ○ Tingling ○ Other _____

Timing ○ Morning ○ Afternoon ○ Night ○ With Activity ○ Constant ○ Intermittent

What makes it Worse? _____

What Makes it Better? _____

Level of Pain and Stress Due to Symptoms CIRCLE THE APPROPRIATE LEVEL WITH **0 = NONE / 10 = EXTREME**

While Resting	0	1	2	3	4	5	6	7	8	9	10
With Activity	0	1	2	3	4	5	6	7	8	9	10

Daily Activities – Effects of Current Condition on Performance

Bending	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Carrying Groceries	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Change Position (Sit-Stand)	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Climb Stairs	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Computer Use	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Driving	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Household Chores	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Job Performance	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Kneeling	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Lifting	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Pet Care	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Reading/Concentration	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Self Care (Bathe/Dress)	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Sexual Activities	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Sleep	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Prolonged Sitting	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Prolonged Standing	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Walking	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Yard Work	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)

Recreational Activities – PLEASE LIST ANY CURRENT RECREATIONAL ACTIVITIES AND THE EFFECTS OF CURRENT CONDITION ON PERFORMANCE

_____	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
_____	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
_____	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
_____	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)

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Confidential Health Record 3/4

Review Of Systems

PLEASE CHECK THE BOXES BELOW THAT APPLY TO YOU. IF NONE OF THEM APPLY, PLEASE CHECK THE **I DENY** BOX IN THE SHADED AREA.

Headaches and Migraines

- I DENY having Any of the Symptoms or Problems Listed Below.

Location	Occipital	Frontal	Left Temporal	Right Temporal	Parietal	Sinus
Quality	Dull	Sharp	Throbbing	Stabbing	Aura	No Aura
Types	Hat Band	Cluster	Migraine	Tension		

Frequency _____ times per _____ **When did they begin?** _____

Nervous System

- I DENY having Any of the Symptoms or Problems Listed Below.
- Dizziness
- Seizures
- Loss of Memory
- Slurred Speech
- Loss Of Consciousness
- Strokes
- Tremor
- Limb Weakness
- Facial Weakness
- Sleep Disturbance
- Stress
- Numbness
- Headache
- Loss of Balance
- Tinnitus/Ringing in Ears

Constitutional

- I DENY having Any of the Symptoms or Problems Listed Below.
- Chills
- Fatigue
- Night Sweats
- Daytime Drowsiness
- Fever
- Weight Loss
- Weight Gain

Respiration

- I DENY having Any of the Symptoms or Problems Listed Below.
- Asthma
- Coughing up Blood
- Sputum Production
- Cough
- Shortness of Breath
- Wheezing

Cardiovascular

- I DENY having Any of the Symptoms or Problems Listed Below.
- Ulcers
- Heart Murmur
- High Blood Pressure
- Orthopnea (Difficulty Breathing Lying Down)
- Chest Pain
- Swelling Of Legs
- Low Blood Pressure
- Claudication (Leg Pain/Ache)
- Palpitations
- Varicose Veins
- Shortness Of Breath
- Angina (Chest Pain or Discomfort)

Gastrointestinal

- I DENY having Any of the Symptoms or Problems Listed Below.
- Diarrhea
- Indigestion
- Abnormal Stool
- Vomiting Blood
- Abnormal Stool Color
- Belching
- Vomiting
- Abdominal Pain
- Black - Tarry Stools
- Nausea
- Heartburn
- Hemorrhoids
- Difficulty Swallowing
- Jaundice
- Constipation
- Rectal Bleeding
- Abnormal Stool Consistency

Psychologic

- I DENY having Any of the Symptoms or Problems Listed Below.
- Irritability
- Convulsions
- Memory Loss
- Behavioral Change
- Anxiety
- Depression
- Mood Change
- Loss or Change in Appetite
- Confusion
- Insomnia
- Bi-Polar Disorder

Allergy

- I DENY having Any of the Symptoms or Problems Listed Below.
- Itching
- Anaphalaxis
- Food Intolerance
- Nasal Congestion
- Rash

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Confidential Health Record 4/4

Health History

Current Medication(s) LIST **ANY/ALL** MEDICATIONS YOU ARE **CURRENTLY** TAKING. BE SPECIFIC. _____

_____

_____

Childhood illness(es) **LIST** ALL HEALTH CONDITIONS. _____

Adult illness(es) **LIST** ALL HEALTH CONDITIONS. _____

_____

Surgery(ies) **LIST** ALL SURGICAL PROCEDURES. WRITE THE **DATE** OF THE PROCEDURE IMMEDIATELY AFTERWARD. _____

_____

_____

Injury(ies) MARK OR LIST ALL INJURIES. WRITE THE **DATE** OF THE INJURY IMMEDIATELY AFTERWARD.

- Back Injury M/D/Y ___/___/___
- Broken Bones M/D/Y ___/___/___
- Laceration (Severe) M/D/Y ___/___/___
- Fracture M/D/Y ___/___/___
- Head Injury M/D/Y ___/___/___
- Loss Of Consciousness M/D/Y ___/___/___
- Disability M/D/Y ___/___/___
- Joint Injury M/D/Y ___/___/___
- Motor Vehicular Crash M/D/Y ___/___/___
- Fall (Severe) M/D/Y ___/___/___

Lifestyle Review

1. Do you believe that it is possible for your body to heal? ○ Yes ○ No
2. What Wellness services/products do you currently incorporate into your lifestyle? _____

   _____
3. What Supplements are you currently taking? _____
4. On a scale of Poor, Good, Excellent please describe your lifestyle MARK **POOR**, **GOOD** OR **EXCELLENT**.

   General Health _____ Sleep _____ Diet _____ Exercise _____

An evaluation will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation and radiological examination (x-rays).

The statements made on this form are accurate to the best of my recollection and I knowingly allow San Diego Spinal Care to examine me for further evaluation.

Signature _____ **Date** M/D/Y ___/___/___

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HIPAA Form
Consent for Purposes of Treatment, Payment & Healthcare Operations

We use and disclose health information about you for care, payment and healthcare operations. For example:

Health Care
We may use or disclose your health information to a physician or other healthcare provider providing care to you.

Your Authorization
In addition to our use of your health information for your care, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends
We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. If you do not wish for this use to be considered please notify us.

Persons Involved in Care
We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to receive x-rays or other similar forms of health information.

Marketing Health-Related Services
We will not use your health information for marketing communications without your authorization.

Required by Law
We may use or disclose your health information when we are required to do so by law.

PATIENT RIGHTS

Access
You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so.

Restrictions
You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication
You have the right to request that we communicate with you about your health information by alternative means, or to alternative locations. Your request must specify the alternative means or location.

Amendment
You have the right to request that we amend your health information. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Notice of Privacy Practices
You have the right to a copy of the Notice of Privacy Practices of Dr. Aaron Kenna upon request and understand that I have a right to review the Notice of Privacy Practices prior to signing this document.

Patient's Name _____ **Signature** _____ **Date** M/D/Y ___/___/___

Doctor of Chiropractic _____ **Signature** _____ **Date** M/D/Y ___/___/___

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Informed Consent
Consent for Purposes of Treatment, Payment & Healthcare Operations

I hereby request and consent to the performance of health care procedures performed by a doctor of chiropractic, including various modes of physical-therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic care and procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct vertebral subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, fees for unused, prepaid treatments can be refunded if you wish to cancel the treatment.

I further understand that there maybe treatment options available for my condition other than chiropractic procedures. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name _____ **Signature** _____ **Date** M/D/Y ___/___/___

Doctor of Chiropractic _____ **Signature** _____ **Date** M/D/Y ___/___/___