

**Dr. Steve Hom, D.C.**

*Family Chiropractor*

Phone: (760) 487-8517

451 La Veta Ave. Encinitas CA 92024

www.indigodragoncenter.com



## Adult Health History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: (mm/dd/yyyy) \_\_\_\_\_ Sex (circle): **M F**

Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Marital Status (circle): **S M W D** Occupation: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Previous chiropractor: \_\_\_\_\_ Last visit: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

**WHY THIS FORM IS IMPORTANT:** Our focus is on assisting people to achieve excellence in health. This is a function of living a continuously more healthful life and improving your body's ability to adapt to your life choices. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can overwhelm the body's general adaptive potential and contribute to other health problems. Our clear goal is to help you realize what is possible for your health. Please complete this form as thoroughly as possible and the doctor will review it with you and have the greatest chance at helping you reach your goals.

**\*Information collected and discussed on this form is strictly confidential and can only be shared with your consent.**

**1. Current Health Concern** (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box)

Health Concern : \_\_\_\_\_

If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) \_\_\_\_\_

Circle or describe its character (sharp, dull, ache, burning, tingling, throbbing, spasms, other)

\_\_\_\_\_

How long have you suffered with this problem? \_\_\_\_\_

What have you tried to get rid of this problem that DID NOT work? \_\_\_\_\_

Have you become discouraged about handling this problem? \_\_\_\_\_

Does it cause problems somewhere else? (circle) **YES NO** If so, where? \_\_\_\_\_

How often does it occur? \_\_\_\_\_

What relieves? \_\_\_\_\_ What aggravates? \_\_\_\_\_

When your problem is at its worst, how does it make you feel? \_\_\_\_\_

How does this problem interfere with the following areas of your life?

Work: \_\_\_\_\_

Family: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Life: \_\_\_\_\_

On a scale of 1 to 10, 10 being the highest, rate your commitment in helping us solve this problem: \_\_\_\_\_

**Other health concerns:** Please note all other health concerns present or in the past.

For women: Are you pregnant? (circle) **Yes No Unknown**

**Disease history: (please check applicable)**

- |                                                     |                                                |                                                  |
|-----------------------------------------------------|------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> High cholesterol        |
| <input type="checkbox"/> Migraines                  | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Hypertension            |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Heart Disease           |
| <input type="checkbox"/> Multiple Sclerosis         | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Parkinson's Disease        | <input type="checkbox"/> Bronchitis            | <input type="checkbox"/> Liver disease           |
| <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Frequent Colds        | <input type="checkbox"/> Kidney Disease          |
| <input type="checkbox"/> Dizziness/Lightheadedness  | <input type="checkbox"/> Immune Deficiencies   | <input type="checkbox"/> Appendicitis            |
| <input type="checkbox"/> Difficulty Concentrating   | <input type="checkbox"/> Tonsillitis           | <input type="checkbox"/> Fatigue                 |
| <input type="checkbox"/> Loss of balance            | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fertility problems      |
| <input type="checkbox"/> Vision changes/Eye disease | <input type="checkbox"/> GI Issues             | <input type="checkbox"/> Miscarriage             |
| <input type="checkbox"/> Numbness and tingling      | <input type="checkbox"/> Difficult digestion   | <input type="checkbox"/> Menstrual Pain/Cramping |
| <input type="checkbox"/> Pinched nerve              | <input type="checkbox"/> Indigestion           | <input type="checkbox"/> Thyroid problem         |
| <input type="checkbox"/> Lowered Resistance         | <input type="checkbox"/> Bloating              | <input type="checkbox"/> Prostate problems       |
| <input type="checkbox"/> Osteoporosis               | <input type="checkbox"/> Heartburn/Acid Reflux | <input type="checkbox"/> Other:                  |
| <input type="checkbox"/> Hernia                     | <input type="checkbox"/> Loose stools          | _____                                            |
| <input type="checkbox"/> Herniated Disc             | <input type="checkbox"/> Diabetes              | _____                                            |

## 2. Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? (circle) **Yes No Unsure**

(if yes please explain) \_\_\_\_\_

Any significant injuries, falls or traumas during adulthood? (circle) **Yes No Unsure**

(if yes please explain) \_\_\_\_\_

Any hospital visits? (circle) **Yes No** Have you had any surgeries, fractures, accidents? **Yes No** Explain and dates \_\_\_\_\_

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) (circle) **Yes No Don't Know**

(if yes, please explain) \_\_\_\_\_

Any hobbies that are physically strenuous or have repetitive movements? (circle) **Yes No Don't Know**

(if yes, please explain) \_\_\_\_\_

What is your usual exercise routine? \_\_\_\_\_

Any fractured bones or dislocations? (circle) **Yes No** What happened and when? \_\_\_\_\_

\_\_\_\_\_

Any vehicle accidents? (circle) **Yes No** What happened and when? \_\_\_\_\_

## 3. Chemical Stresses

Are you taking prescription or over-the-counter medications? (circle) **Yes No** (If yes, please indicate what you are taking and why) \_\_\_\_\_

\_\_\_\_\_

Are you currently taking supplements? (circle) **Yes No** (if yes, which ones and why?) \_\_\_\_\_

\_\_\_\_\_

Do you smoke? (circle) **Yes No Quit** (if yes how much?) \_\_\_\_\_

Do you drink? (circle) **Yes No** (if yes roughly how much?) \_\_\_\_\_

Are you happy with your diet? (circle) **Yes No** Do you wish assistance with it? (circle) **Yes No**

Do you drink good quality water? (circle) **Yes No Occasionally** How much per day? (oz.) \_\_\_\_\_

Do you drink bottled water? (circle) **Yes No Occasionally**

Are you exposed to pollutants, strong smells, chemicals, aerosols? (circle) **Yes No Occasionally**

Do you eat organic? (circle) **Yes No Occasionally**

Do you use natural or environmentally friendly products in your home? (i.e. cleaning supplies, hair and makeup, etc. (circle) **Yes No** \_\_\_\_\_

Do you drink or bathe/shower in tap (chlorinated water)? (circle) **Yes No** \_\_\_\_\_

#### 4. Mental/Emotional Stresses

**As psychological stress has been shown to negatively affect many systems, please let us know how you are coping with life's stresses.**

If you are experiencing significant or ongoing stress please explain \_\_\_\_\_

Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? (circle) **Yes No** Explain \_\_\_\_\_

Are you interested in learning about stress reduction practices? (circle) **Yes No**

How is your sleep? Please rate on a scale between 1 and 10 (1 is poor and 10 is excellent) \_\_\_\_\_

How much do you get per night? (hrs.) \_\_\_\_\_

**Please check the boxes where you experience stress the most:**

- |                                             |                                               |                                       |
|---------------------------------------------|-----------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Life in General    | <input type="checkbox"/> Financial Stress     | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Time Management    | <input type="checkbox"/> Symptom Management   | _____                                 |
| <input type="checkbox"/> Physical Activity  | <input type="checkbox"/> Health and Wellbeing | _____                                 |
| <input type="checkbox"/> Work and Career    | <input type="checkbox"/> Quality of Sleep     | _____                                 |
| <input type="checkbox"/> Sports and Hobbies | <input type="checkbox"/> Relationships        |                                       |

#### 5. Why are you here?

**People seek chiropractic care for several reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes.**

- |                                                    |                                                           |                                             |
|----------------------------------------------------|-----------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Pain Reduction            | <input type="checkbox"/> Keep Me Moving                   | <input type="checkbox"/> Symptom Management |
| <input type="checkbox"/> Relief                    | <input type="checkbox"/> Improved Performance             | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> Improved Quality of Life  | <input type="checkbox"/> Full Body Integration            | _____                                       |
| <input type="checkbox"/> Manage My Crisis          | <input type="checkbox"/> Wellness                         | _____                                       |
| <input type="checkbox"/> Information on Prevention | <input type="checkbox"/> Longevity                        | _____                                       |
| <input type="checkbox"/> Stress Reduction          |                                                           |                                             |
| <input type="checkbox"/> Healthier Immune System   | <input type="checkbox"/> Optimum Function/Quality of Life |                                             |

**In 6-12 months, if you could have anything for your health, what would you want? List 3 goals:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## 6. Family Health History

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces and do not apply.

Condition	Father	Mother	Spouse	Siblings		Children			
	Age	Age	Age	Age	Age	Age	Age	Age	Age
ADHD									
Allergies									
Arthritis									
Asthma									
Autism									
Back Trouble									
Bed Wetting									
Bursitis									
Cancer									
Chest Pain									
Colic									
Constipation									
Crohn's Disease									
Depression									
Diabetes									
Diarrhea									
Disc Problems									
Down Syndrome									
Ear Infection									
Emotion Issues									
Emphysema									
Epilepsy									
Headaches									
Migraines									
Heartburn									
Heart Trouble									
High Blood Press									
IBS									
Indigestion									
Infertility									
Insomnia									
Kidney Trouble									
Neck Pain									
Neuritis									
Nervousness									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Other									

# Our Fee Structure

Please note our office fees for your initial visit include:

<i>Consultation</i>	Complimentary
<i>Examination and Adjustment</i>	\$249.00 (Referred Patients \$149.00)
<i>X-rays (if applicable)</i>	\$100.00 (referral to Imaging Healthcare Specialists)
<b>TOTAL</b>	<b>\$149.00 - \$349.00</b>

Please let us know if you, or your spouse is active duty military or veteran. As a thank you to our service members, we offer an additional 10% discount on all regular visit rates.

\* Following your initial visit, subsequent family members' initial appointments are subject to the discounted rate of \$100 per visit (including consultation, examination and adjustment).

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Signature of Parent/Guardian required if patient under age 18)

***Thank You!***

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# Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to STEPHEN M HOM CHIROPRACTIC, INC. to use and/or disclose Protected Health Information in accordance with the following:

## SPECIFIC AUTHORIZATIONS:

- I give permission to STEPHEN M HOM CHIROPRACTIC, INC. to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If STEPHEN M HOM CHIROPRACTIC, INC. contacts me by phone, I give them permission to leave a voice mail.
- I give permission to STEPHEN M HOM CHIROPRACTIC, INC. to use my photograph marketing materials such as their brochure, website, social media and ads in print media.
- I give permission to STEPHEN M HOM CHIROPRACTIC, INC. to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give STEPHEN M HOM CHIROPRACTIC, INC. permission to treat me in an open room where other patients may also be treated. I am aware that other persons in the office may overhear some of my protected health information during care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving STEPHEN M HOM CHIROPRACTIC, INC. permission to use and disclose your protected health information in accordance with the directives listed above.

*The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at STEPHEN M HOM CHIROPRACTIC, INC. plus 7 years or until revoked by me.*

## RIGHT TO REVOKE AUTHORIZATION:

*You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or acted in reliance on your authorization.*



You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of STEPHEN M HOM CHIROPRACTIC, INC.. The written notice must contain the following information:

1. Your name
2. Social Security number
3. Date of Birth
4. A clear statement of your intent to revoke this authorization
5. The date of your intent to revoke this authorization and your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by STEPHEN M HOM CHIROPRACTIC, INC. for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this **authorization**. If I refuse to sign this **authorization**, STEPHEN M HOM CHIROPRACTIC, INC. will not refuse to provide treatment however, it will not be possible for STEPHEN M HOM CHIROPRACTIC, INC. to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since STEPHEN M HOM CHIROPRACTIC, INC. will be unable to contact me 3) all contact with STEPHEN M HOM CHIROPRACTIC, INC. regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

#### HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's name (please print): \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

#### **Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)**

Parent or Personal Representative name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Description of Representative's Authority to Act on Patient's Behalf: \_\_\_\_\_

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## Your Informed Consent

In order for my health professional, as indicated below, to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so, by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not, is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the Chiropractor continues to be obligated for best practices delivered in my interests.

*We would like all of our new patients to understand that Chiropractor's possess the lowest malpractice insurance premiums of all the health care professions in the world. Chiropractic care maintains significantly less risk compared to traditional medical, drug and surgical care professions, which account for approximately 200,000 annual deaths in North America alone. Chiropractic is your safest option in the health care system.*

*Although Chiropractic is reported to be the safest health care system in the world, we feel that it is responsible to let you know:*

- a. Risk of stroke is reported to be 1 in 5-8 million and the cause has yet to be determined.*
- b. While extremely rare, there have been reports of ligament sprains and even rib fractures reported.*
- c. There have been rare reports of disc injuries, although no clinical scientific study has ever demonstrated chiropractic care to be the cause.*

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor.

I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Center. This consent applies to all present and future care for my family and me.

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Your Signature: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_