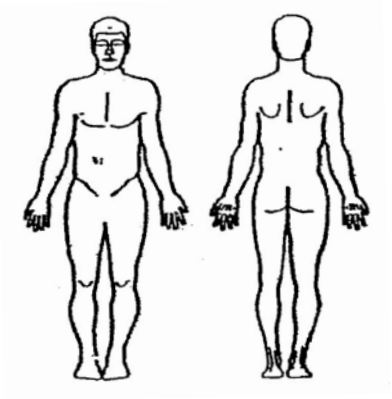
THE CENTER FOR HEALTH & WELLBEING
mindful medicine

Janette J. Gray, M.D., Inc.

Chiropractic Initial Health Status Form

Patient's Name: _____ Date of Service: _____
Date of Birth: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____
_____
_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A
DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? ☐ 0–25% ☐ 26–50% ☐ 51–75% ☐ 76–100%
Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____
_____
HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes Date(s) taken:_____
WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, # of births _____
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteriod Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (date) _____	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Surgeries/Medications/Supplements: _____
☐	☐	Cancer/Tumor			_____
☐	☐	Osteoporosis			_____
☐	☐	Recent Trauma			_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____

THE CENTER FOR HEALTH & WELLBEING
mindful medicine

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, associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral 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 judgement during the course of the procedures which the doctor feels at the time, based upon the facts then known, 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 weighed 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 my present condition and for any future conditions for which I seek treatment.

The Center for Health and Wellbeing
www.chwbonline.com
3636 5th Avenue Suite 300
San Diego, CA 92103
Phone 619-814-5500
Fax 619-794-0260

Print Name(s) of Doctor Treating This Patient

_____

_____

_____

DO NOT SIGN UNTIL YOU 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 _____

THE CENTER FOR HEALTH & WELLBEING
mindful medicine

Janette J. Gray M.D., Inc.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on June 14, 2007 and remains in effect until we replace it.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

Law requires us to:

1. Follow the terms of the notice that is now in effect.
2. Keep your medical information private.
3. Give you this notice describing our legal duties, privacy practices, and your rights regarding medical information.

We Have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practice, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We my disclose medical information about you to doctors, nurses, medical assistants, technicians, medical students, or other people who are taking care of you. We may also share medical information to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

NOTIFICATION: Medical information to notify: a family member, your personal representative or another person responsible for your care. We will get your permission before we share medical information, or give you the opportunity to refuse permission. In case of emergency, and you are unable to give permission we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

APPOINTMENT REMINDERS AND HEALTH-RELATED INFORMATION:
Covered entity may contact the individual to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to the individual.

RESEARCH IN LIMITED CIRCUMSTANCES: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to insure the privacy of medical information.

USES AND DISCLOSURES FOR WHICH NO PERMISSION IS REQUIRED:

PUBLIC HEALTH REPORTING: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements. To track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or other wise be at risk of contracting or spreading a disease or condition.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

WORKERS COMPENSATION: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

HEALTH OVERSIGHT ACTIVITIES: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

COURT ORDERS AND JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose medical information in response to court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share you medical information with law enforcement officials. We may share limited information with law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

YOUR INDIVIDUAL RIGHTS

YOU HAVE A RIGHT TO:

1. Look at or get copies of your medical information. You may also request copies by filling out a release form from our office which will be handled by the medical records department. If you request copies, there will be a per-page charge and a postage charge. Contact our medical records department for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency.)
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the medical records department.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact our privacy officer. You may also submit written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health an Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided and opportunity to review it.

NAME: _____ DOB: _____

SIGNATURE: _____ DATE: _____