

# INFORMATION/APPLICATION FOR CARE

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The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT.**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Age \_\_\_\_\_ Birth date \_\_\_\_\_ Marital Status: S M W D Number of Children \_\_\_\_\_  
 Your Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Please circle one payment type: Cash Check Master Card/Visa  
 Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years On Job \_\_\_\_\_  
 Do you have Medical Insurance? Yes \_\_\_ No \_\_\_ Do you have Medicare? Yes \_\_\_ No \_\_\_  
 Name of Spouse or Parent \_\_\_\_\_ Their Birthdates \_\_\_\_\_

Referred to our office by: \_\_\_\_\_ Phone \_\_\_\_\_

## MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your condition due to an accident? Yes \_\_\_ No \_\_\_ Date of accident? \_\_\_\_\_  
 Type of accident? Auto \_\_\_ Work/On Job \_\_\_ At Home \_\_\_ Other \_\_\_\_\_  
 Have you ever been in an auto accident? Past Year \_\_\_ Past 5 Years \_\_\_ Over 5 Years \_\_\_ Never \_\_\_

## INSTRUCTIONS

**Circle the appropriate number for each question according to the following scale:**

**0 = NONE, not a problem; 1 = SLIGHT amount, or rarely;**

**2 = MODERATE, some; 3 = ACUTE, a lot, frequently**

<u>1 – GLANDULAR</u>		<u>2 – ELIMINATE</u>	
1. Sensitive or tender skin	0 1 2 3	1. Abnormal or excessive foot odor	0 1 2 3
2. Cuts in skin heal slowly	0 1 2 3	2. Abnormal or excessive body odor	0 1 2 3
3. Face flushes badly	0 1 2 3	3. Frequent clearing or lump in throat	0 1 2 3
4. Perspire a great deal	0 1 2 3	4. Excessive spells of sneezing	0 1 2 3
5. Itchy scalp, dry scaly skin, or rash	0 1 2 3	5. Nose bleeds	0 1 2 3
6. Lack energy	0 1 2 3	6. Have colds or suffer from chest colds	0 1 2 3
7. Poor memory	0 1 2 3	7. Cough or spitting up phlegm (mucus)	0 1 2 3
8. Dry, brittle hair or oily hair and scalp	0 1 2 3	8. Soaking sweats during sleep	0 1 2 3
9. Lose control of bladder	0 1 2 3	9. Chronic chest condition	0 1 2 3
10. Enlarged glands	0 1 2 3	10. Painful, diminished or frequent urination	0 1 2 3
11. Get upset, irritated or short temper	0 1 2 3	11. Troubled with complexion	0 1 2 3
12. Lack of ability to concentrate	0 1 2 3	12. Congested breathing or wheezing	0 1 2 3
13. Spells of exhaustion or fatigue	0 1 2 3	13. Inflamed or irritated bladder function	0 1 2 3
14. Get up tired and exhausted	0 1 2 3	14. Constipated or diarrhea	0 1 2 3
15. Tire easily or nervous exhaustion	0 1 2 3	15. Runny nose (not during a cold)	0 1 2 3
TOTAL _____		TOTAL _____	

**Continue on the next page**

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<p><b><u>3 – NERVE</u></b></p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>1. Eye blink or water</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>2. Sties, pain, or eyes red/inflamed</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>3. Draining, hearing difficulty, noise in ears</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>4. Double vision or total black outs</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>5. Lack of sensation anywhere in the body</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>6. Senses of smell or taste poor</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>7. Suffer from headaches</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>8. Hot or cold spells</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>9. Dizzy spells or feelings or faintness</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>10. Twitching of head, face, shoulders, etc.</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>11. Bite fingernails or cuticles</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>12. Some stuttering or stammering</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>13. Difficulty <u>falling</u> asleep or <u>staying</u> asleep</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>14. Inability to relax</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>15. Loss of sex drive</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>TOTAL</td><td style="text-align: right;">_____</td></tr> </tbody> </table>	1. Eye blink or water	0 1 2 3	2. Sties, pain, or eyes red/inflamed	0 1 2 3	3. Draining, hearing difficulty, noise in ears	0 1 2 3	4. Double vision or total black outs	0 1 2 3	5. Lack of sensation anywhere in the body	0 1 2 3	6. Senses of smell or taste poor	0 1 2 3	7. Suffer from headaches	0 1 2 3	8. Hot or cold spells	0 1 2 3	9. Dizzy spells or feelings or faintness	0 1 2 3	10. Twitching of head, face, shoulders, etc.	0 1 2 3	11. Bite fingernails or cuticles	0 1 2 3	12. Some stuttering or stammering	0 1 2 3	13. Difficulty <u>falling</u> asleep or <u>staying</u> asleep	0 1 2 3	14. Inability to relax	0 1 2 3	15. Loss of sex drive	0 1 2 3	TOTAL	_____	<p><b><u>4 - DIGESTIVE</u></b></p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>1. Coated tongue</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>2. Poor appetite or excessive hunger</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>3. Do not eat regular meals 3 X a day</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>4. Eat sweets between meals</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>5. Eat other foods between meals</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>6. Must be careful of what you eat</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>7. Feel bloated</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>8. Indigestion, gas or excessive thirst</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>9. Heartburn or vomiting</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>10. Nauseous (feel sick in stomach)</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>11. Bad breath or bad taste in mouth</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>12. Hemorrhoids or rectal bleeding</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>13. Brownish spots on skin</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>14. Pains in lower abdomen</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>15. Drink sweet drinks between meals</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>TOTAL</td><td style="text-align: right;">_____</td></tr> </tbody> </table>	1. Coated tongue	0 1 2 3	2. Poor appetite or excessive hunger	0 1 2 3	3. Do not eat regular meals 3 X a day	0 1 2 3	4. Eat sweets between meals	0 1 2 3	5. Eat other foods between meals	0 1 2 3	6. Must be careful of what you eat	0 1 2 3	7. Feel bloated	0 1 2 3	8. Indigestion, gas or excessive thirst	0 1 2 3	9. Heartburn or vomiting	0 1 2 3	10. Nauseous (feel sick in stomach)	0 1 2 3	11. Bad breath or bad taste in mouth	0 1 2 3	12. Hemorrhoids or rectal bleeding	0 1 2 3	13. Brownish spots on skin	0 1 2 3	14. Pains in lower abdomen	0 1 2 3	15. Drink sweet drinks between meals	0 1 2 3	TOTAL	_____
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I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.  
 Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

**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.

Aaron Orpelli DC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

**Disclosure of your Health Care Information**

**Treatment**

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. Aaron Orpelli, D.C. is practicing chiropractic care in an open space area.

**Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.

**Changes to this Notice of Privacy Practices**

Aaron Orpelli DC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Aaron Orpelli DC is required by law to comply with this Notice.

Aaron Orpelli DC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact: Dr. Aaron Orpelli by calling this office at (310) 278-4567. If Dr. Aaron Orpelli is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

DHHS, Office of Civil Rights , 200 Independence Avenue, S.W. Room 509F HHH Building, Washington, DC 20201

**This notice is effective as of 04-01-03**

**Patient's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Aaron Orpelli DC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

**Signature: Aaron Orpelli, D.C.**