

# West Olympic Chiropractic

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E mail: \_\_\_\_\_

SS# \_\_\_\_\_ DL# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Number of Children: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name & Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone: \_\_\_\_\_

**On a scale from 1-10, describe your stress level: (1 = none, 10 = extreme)** Occupation: \_\_\_\_\_ Personal: \_\_\_\_\_

**On a scale of Poor, Good, or Excellent, describe you're:**

	Poor	Good	Excellent
Diet:	_____	_____	_____
Exercise:	_____	_____	_____
Sleep:	_____	_____	_____
General Health	_____	_____	_____

### ADDRESSING THE ISSUES THAT BRINGS YOU TO THE OFFICE

If you have no symptoms and are here for wellness services, please check here:

\_\_\_\_\_ I wish to have chiropractic wellness service (please skip the health profile)

Briefly describe the issue that brings you to the office, including the affect it has had on your life:

\_\_\_\_\_  
 \_\_\_\_\_

**Other Doctors seen for this problem (please list):** Chiropractor: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Other: \_\_\_\_\_

**List any medications you are taking:** \_\_\_\_\_

<p><b>MEN only</b></p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Lump in testicles</p> <p><input type="checkbox"/> Penis discharge</p> <p><input type="checkbox"/> Sore on penis</p> <p><input type="checkbox"/> Other</p>	<p><b>WOMEN only</b></p> <p><input type="checkbox"/> Abnormal pap smear</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Nipple discharge</p>	<p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Vaginal discharge</p> <p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Date of last mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or missions that I may have made in the completion of this form.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## 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**

<p><b><u>1 – GLANDULAR</u></b></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>1. Sensitive or tender skin</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>2. Cuts in skin heal slowly</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>3. Face flushes badly</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>4. Perspire a great deal</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>5. Itchy scalp, dry scaly skin, or rash</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>6. Lack energy</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>7. Poor memory</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>8. Dry, brittle hair or oily hair and scalp</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>9. Lose control of bladder</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>10. Enlarged glands</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>11. Get upset, irritated or short temper</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>12. Lack of ability to concentrate</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>13. Spells of exhaustion or fatigue</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>14. Get up tired and exhausted</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>15. Tire easily or nervous exhaustion</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td><b>TOTAL</b></td><td style="text-align: right;">_____</td></tr> </table>	1. Sensitive or tender skin	0 1 2 3	2. Cuts in skin heal slowly	0 1 2 3	3. Face flushes badly	0 1 2 3	4. Perspire a great deal	0 1 2 3	5. Itchy scalp, dry scaly skin, or rash	0 1 2 3	6. Lack energy	0 1 2 3	7. Poor memory	0 1 2 3	8. Dry, brittle hair or oily hair and scalp	0 1 2 3	9. Lose control of bladder	0 1 2 3	10. Enlarged glands	0 1 2 3	11. Get upset, irritated or short temper	0 1 2 3	12. Lack of ability to concentrate	0 1 2 3	13. Spells of exhaustion or fatigue	0 1 2 3	14. Get up tired and exhausted	0 1 2 3	15. Tire easily or nervous exhaustion	0 1 2 3	<b>TOTAL</b>	_____	<p><b><u>2 – ELIMINATE</u></b></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>1. Abnormal or excessive foot odor</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>2. Abnormal or excessive body odor</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>3. Frequent clearing or lump in throat</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>4. Excessive spells of sneezing</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>5. Nose bleeds</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>6. Have colds or suffer from chest colds</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>7. Cough or spitting up phlegm (mucus)</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>8. Soaking sweats during sleep</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>9. Chronic chest condition</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>10. Painful, diminished or frequent urination</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>11. Troubled with complexion</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>12. Congested breathing or wheezing</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>13. Inflamed or irritated bladder function</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>14. Constipated or diarrhea</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td>15. Runny nose (not during a cold)</td><td style="text-align: right;">0 1 2 3</td></tr> <tr><td><b>TOTAL</b></td><td style="text-align: right;">_____</td></tr> </table>	1. Abnormal or excessive foot odor	0 1 2 3	2. Abnormal or excessive body odor	0 1 2 3	3. Frequent clearing or lump in throat	0 1 2 3	4. Excessive spells of sneezing	0 1 2 3	5. Nose bleeds	0 1 2 3	6. Have colds or suffer from chest colds	0 1 2 3	7. Cough or spitting up phlegm (mucus)	0 1 2 3	8. Soaking sweats during sleep	0 1 2 3	9. Chronic chest condition	0 1 2 3	10. Painful, diminished or frequent urination	0 1 2 3	11. Troubled with complexion	0 1 2 3	12. Congested breathing or wheezing	0 1 2 3	13. Inflamed or irritated bladder function	0 1 2 3	14. Constipated or diarrhea	0 1 2 3	15. Runny nose (not during a cold)	0 1 2 3	<b>TOTAL</b>	_____
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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**West Olympic Chiropractic**

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.

West Olympic Chiropractic. 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**

West Olympic Chiropractic 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, West Olympic Chiropractic is required by law to comply with this Notice.

West Olympic Chiropractic 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 West Olympic Chiropractic 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.

Facility signature: **West Olympic Chiropractic**