SOL SANTA CRUZ
REHAB TO PERFORMANCE

CHIROPRACTIC

New Patient Information

Date: ____/_____/_____

WELCOME! PLEASE TELL US ABOUT YOURSELF:

Full Name:_____ Gender: ☐M ☐F Age: _____ Birth Date: ____/____/____

Address: _____City:_____ State: _____ Zip: _____

Home phone: (_____)_____

E-mail: _____ Work phone: (_____)_____

Cell Phone: (_____)_____

Social Security #: _____-_____-_____ Drivers License #:_____ Fax: (_____) _____

Marital Status: ☐S ☐M ☐D ☐W # of Children: _____ Work Status: ☐Full-time ☐Part-time ☐Retired

Employer: _____ Occupation:_____

Employer Address: _____ City: _____ State: _____ Zip: _____

Females: Last Menstrual Period: _____ Pregnant? ☐Y ☐N Nursing? ☐Y ☐N

Name of Spouse, Parent or Guardian: _____ Employer:_____

Occupation: _____ Work Phone: (____)_____

In Case of an Emergency Contact: _____ Relationship: _____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

How did you hear about our clinic? Who may we thank for referring you? _____

TREATMENT YOU ARE SEEKING:

□ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
□ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
□ I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: □Y □N
If yes, whom? _____ Treatment(s): _____
Have you had any intolerance or reactions to treatments? □Y □N Describe: _____
Is this a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____ Has it become worse recently? □Y □ N describe: _____
How frequent is the condition? □Constant □Daily □Intermittent □Night Only.
How long does it last? □All day □Few hours □Minutes
Is this condition interfering with your : □Work □Sleep □Daily routine □Recreation □Other: _____
How long has it been since you really felt good? □Days □Weeks □Months □Years □ > 10 years
Describe the pain: □Sharp □Dull □Numbness □Tingling □Aching □Burning □Stabbing □Other
Is there anything that you can do to relieve the problem? □Y □N If yes, describe: _____
If no, what have you tried to do that has no helped? _____
What do you believe is wrong with you? _____
Are there any other conditions or symptoms that may be related to your major symptom? □Y □N If yes, what?_____
Have you been in an auto accident? □ Past year □ Past 5 years □Over 5 years □Never
Describe: _____

HEALTH CONCERNS: Please list your top health concerns in order of priority

1) _____
2) _____
3) _____

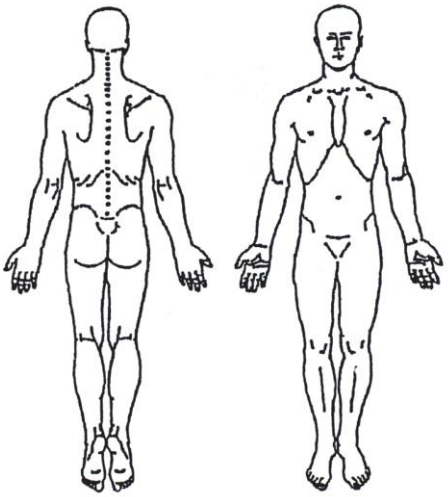
Please check all of the symptoms that apply. (P=Past / C=Current)

P/C	P/C	P/C
□□Headache	□□Sweating	□□Fatigue
□□Facial pain	□□Insomnia	□□Menstrual irregularities
□□Eye pain	□□Fainting	□□Elbow/ Hand Pain
□□Blurred vision	□□Low Blood Pressure	□□Tingling in Hands
□□Dizziness	□□Abdominal Pain	□□Clammy Hands
□□Earache	□□Nausea/ vomiting	□□Low Back Pain
□□Forgetfulness	□□Poor Appetite	□□Hip Pain
□□Confusion	□□Fullness of Bladder	□□Knee Pain
□□Sinusitis	□□Urination Difficulty	□□Poor Circulation
□□Teeth Grinding	□□Frequent Urination	□□Swollen Joints
□□Dry mouth	□□Constipation	□□Joint Stiffness
□□Excessive Thirst	□□Hemorrhoids	□□Swollen Ankles
□□Unpleasant Taste	□□Decreased Sex Drive	□□Ankle/foot Pain
□□Neck Pain	□□Shoulder Pain	□□Tingling in Feet
□□Persistent Coughing	□□Swallowing Pain	□□Walking Problems
□□Unsteady Voice	□□Lump in Throat	□□Sore muscles
□□Chest Pressure	□□Sore Throat	□□Weak Muscles
□□Slow Heart Rate	□□Convulsions	□□Paralysis
□□Rapid Heart Rate	□□Irritability	□□Shaking
□□High Blood Pressure	□□Impatience	□□Feel Loss of Control

□□Other_____

Please use the legend symbols below to accurately mark the areas in which you Feel these sensations

Stabbing/Cutting -/// Tingling - T
Burning – XXX Cramping - C
Numbness - ~~ Dull - ###



ALLERGIES: Please check and list all allergies.

☐ Food: _____

☐ Medications: _____

☐ Seasonal / Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date started
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone replacements (HRT)		
☐ Oral Contraceptives		
☐ Other		

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had.

_____
_____
_____

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N
If yes, which and how frequently? _____
Who recommended them?_____

HABITS:	**Heavy**	**Moderate**	**Light**	**None**	**Describe, if you would like**
Alcohol	☐	☐	☐	☐	_____
Coffee	☐	☐	☐	☐	_____
Soda / Diet Soda	☐	☐	☐	☐	_____
Tobacco	☐	☐	☐	☐	_____
Drugs	☐	☐	☐	☐	_____
Stress Level	☐	☐	☐	☐	_____

	8+ hrs	**7-8hrs**	**6-7 hrs**	**5-6hrs**	**<5hrs**	**Quality**
Sleep	☐	☐	☐	☐	☐	_____

	5-7x/wk	**3-5x/wk**	**1-3x/wk**	**None**	**Type(s)**	**Time Spent**
Exercise	☐	☐	☐	☐	_____	_____

	64+oz	**32-64 oz**	**16-32 oz**	**<8 oz**
Water/day	☐	☐	☐	☐

	5+	**4**	**3**	**2**
Meals/day	☐	☐	☐	☐

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly sitting ☐ Mostly standing ☐ Walking/Moving ☐Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

___Alcoholism	___Eczema	___Miscarriage(s)	___Tumor(s)
___Anemia	___Emphysema	___Mumps	___Ulcer(s)
___Cancer	___Epilepsy	___Pleurisy	___Other: _____
___Cold sores	___Goiter	___Pneumonia	_____
___Deep Vein Thrombosis	___Gout	___Polio	_____
___Detached retina	___Heart disease	___Rheumatic fever	
___Diabetes	___HIV/AIDS	___Stroke	

_____
Patient's Printed Name

_____ _____
Patient's Signature **Date**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I, the undersigned, hereby acknowledge and understand that I am a patient of Karen K. Roitz, D.C., DACBSP, Doctor of Chiropractic located at 1510 Seabright Avenue, Santa Cruz, CA 95062. I further understand that the chiropractic services provided at this location are not a part of a group practice or partnership. My chiropractic care is exclusively provided by Karen K. Roitz, D.C., DACBSP and no other individual entity providing other services at this location. Should you require treatments or services other than those provided by Karen K. Roitz, D.C., DACBSP separate agreements and consent forms with such practitioners and professional will be required prior to treatment. Karen K. Roitz, D.C., DACBSP is not responsible for any treatments or services provided by other licensed practitioners or professionals—even if such treatments or services are provided in the shared SŌL Santa Cruz facility.

I hereby request and consent to the performance of Chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays and physiotherapy techniques, on me (or 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 or Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as a backup for the doctor(s) or Chiropractic named below.

I understand that, as with all health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications may include, but are not limited to, fractures, disk injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation or 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 judgment 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 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.

[continued on next page]

_____ (Initial Here)

Continuation of Informed Consent to Treat

Please check the appropriate box:

I have read □ or have had read to me □ the above explanation or 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.

Karen K. Roitz, DC, DACBSP

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE AND HAVE CHECKED AND INITIALED THE APPROPRIATE BOXES ON THE 1ST PAGE

Printed Patient Name	Date
Signature of Patient	Date
Signature of Patient's Representative	Date
Witness to Patient's Signature	Date
Translated By	Date

Financial Policy & Agreement

Cash or Insurance Patients

We would like to take a moment to welcome you to our office and familiarize you with our financial policy. All of our fees are based upon individual services rendered, and may vary from visit to visit, depending upon the doctors' recommendations for your needs. A complete list of services available can be provided at the front desk.

Within the first week of treatment, we will verify your insurance benefits. The verification is only an estimated summary of benefits provided by your insurance company and does not guarantee payment by your insurance, or the coverage amount that we are quoted.

We provide insurance billing services as a courtesy to our patients, and are contracted with many insurance companies. We also bill companies that we are not contracted with (dependent upon the policy's out-of-network benefits). For patients without insurance coverage, or out-of-network plans not eligible for billing through our service, we offer a Pay-at-time-of-Service, discounted "cash" rate.

We will only bill your insurance; we do not provide collection services.
At the time of service, you will be responsible for payment of any amount towards your deductible, co-payments, or co-insurances due, as according to our verification of your benefits. If there is a discrepancy between a payment you have made and what is allowed by the insurance company once the claim has processed, you will be credited or billed. If your account becomes grossly past due (120+ days) there will be a *20% annual interest rate charge, which will accrue on a monthly basis until the balance is paid in full.*

To help you keep your scheduled appointments, we offer appointment reminders (a call or text message) that will notify you the day prior to your scheduled appointment.
If you cancel your appointment with less than 24 hours notice, or do not show for a scheduled visit, you will be billed for the practitioner's time ($45 for a Chiropractic visit, or $45 for ancillary services: Massage Therapy, Strength/Training, Pilates).

My signature denotes that I have read, understand and agree to the above.

_____ _____

Patient or guardian signature Date

HIPAA REGULATIONS

Privacy Practices

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. 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

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices. This is listed on our website: www.solsantacruz.net

Use and Disclosure

The following are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to *your* other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any question about any of our policies or your rights, please feel free to speak with your chiropractic physician or any of our staff.

Your signature below indicates your understanding of and compliance with the above privacy practices.

_____ _____

Printed Name Date

_____

Signature

SOL SANTA CRUZ DISCLOSURE FORM

As a facility, SOL Santa Cruz offers many various services through multiple disciplines and providers.

Please indicate which of the following treatments you are seeking today:

Initial on the appropriate line below:

_____ Physical Therapy services provided by Christopher Taquino, DPT

_____ Chiropractic services provided by Karen Roitz, DC, DACBSP

_____ Massage Therapy Services

_____ Pilates Training Services

_____ Athletic Training/ Strengthening Services

By signing below, I hereby acknowledge all of the following:

- I understand that SOL Santa Cruz:
  (a) is the trade name under which various independent medical practitioners and professionals market their services and share office space;
  (b) does not provide any patient or other services;
  (c) is not a group practice or partnership.

- All of the services offered at this location and provided by independent licensed practitioners or professionals, who will each require my individual consent prior to providing treatment or providing services, and who are solely responsible for my treatment of well being while at this facility.

- Should I require treatment by more than one named individual or entity above, I will be required to sign separate agreement and consent forms with such individual or entity, prior to treatment. Aside from the services selected above, no other practitioners or professionals shall be held responsible for my care or well being – even if such services are provided in the shared SOL Santa Cruz facility.

_____ _____

Print Name Date

_____

Signature

CHIROPRACTIC CARE COVID-19 CONSENT

I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks and give consent to receive Chiropractic care at SOL Santa Cruz from this practitioner.

I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at SOL Santa Cruz tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

_____ _____

Print Name Date

_____

Signature