CASE HISTORY

Name ____ Date ________ E-mail ______________________
Address ________________________________ City __________________ State ________ Zip ________
Telephone __________________________ Soc Sec # __________________ Driver Lic # ______________
Age ________________ Date of Birth _________ Sex __________ Status M S W D #. of Children ____
Occupation _________________________ Employer _____________________________ Yrs Employed __
Employers Address _______________________ City ___________________ State __________ Zip ______
Spouse's Name _________________________ Occupation ________________ Employer ______________
Person responsible for this account __________________________________ Referred by ______________

What is your major complaint? ____

____

Other complaints ____
How long have you had this condition _____________ Have you had this or similar conditions in the past ? ___
What activities aggravate your condition? ____
Is this condition getting progressively worse? Y ☐ N ☐ Constant ☐ Comes and goes ☐
Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other: ___________________
How long has it been since you felt really good? ______________
List surgical operations: ____

____

Are you taking any medications? _____ What kind? ____
Any non-prescription drugs? _______ What kind? ____
OTHER DOCTORS SEEN FOR THIS CONDITION: MD ☐ DC ☐ DO ☐ Other ___________________
Doctor's name: ____ Diagnosis ___________________
X-rays ________________ Urinalysis ___________ Blood tests _____________ Other _______________
Treatment: Medication ______________________ Physiotherapy _________________________________
Results _________________ Length of time under care ________________
Were you off work ___ If so, how long ____ Have you returned to the same job? __ If not, why? _____________

ACCIDENT INFORMATION

Did your accident occur while at work? Y ☐ N ☐ Were you involved in an automobile accident? Y ☐ N ☐
Date ________ Time ______ Injury reported to employer: Y ☐ N ☐ Supervisor ___________________
Description of accident: ____

____

Were you injured? Y ☐ N ☐ How ____
Location: ____
Were you unconscious ______ Fractures _______ Cuts __________ Abrasions _____ Bruises __________
Patient taken to ______________________________ Hospital for __________________________ treatment
Confined to hospital for: ____ days _____ hours. Name of hospital doctor __________________________
Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 year s ☐ Over 5 years ☐ none
Describe: ____
Do you have an attorney Y ☐ N ☐ Name and Address ____
Phone ______________________ ____

INSURANCE INFORMATION

Are you covered by Medicare? Y ☐ N ☐ Medicare # _________________ State Insurance Aid? Y ☐ N ☐
Do you have any group, union, or personal health and accident insurance : Y ☐ N ☐
Name of Insurance Company ______________________________ Claim # __________ Group #___________
Address ____________________________________ Phone ________________ Agent _______________
Additional Insurance Company _____________________________ Claim # __________ Group # __________
Address ____________________________________ Phone ________________ Agent _______________
Is you condition due to an accident? ☐ illness ☐ other ______________________________________

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patients Signature ____ Date ____________________

Patient: ____________________________________ **Date**: ___________ **Dr. Steven Rottell, D.C.**

REVIEW OF SYSTEMS

Please check any conditions or symptoms that apply. P = Past C = Current

P	C	Personal History
❑	❑	Trauma/Injuries
❑	❑	Height Change
❑	❑	Weight Change
❑	❑	Fever/Chills/Sweats
❑	❑	HIV Positive
❑	❑	Allergies
❑	❑	Anemia
❑	❑	Bleeding/Bruising
❑	❑	Malaise/Fatigue/Weakness
P	**C**	**Family History**
❑	❑	Diabetes
❑	❑	Thyroid Disease
❑	❑	Tuberculosis
❑	❑	Kidney Disease
❑	❑	High Blood Pressure
❑	❑	Heart Disease/Stroke
❑	❑	Musculoskeletal Disease
❑	❑	Cancer
P	**C**	**Endocrine System**
❑	❑	Heat/Cold Intolerance
❑	❑	Thyroid Problems
❑	❑	Diabetes
❑	❑	Neck Surgery/Irradiation
❑	❑	Hormone Replacement
P	**C**	**Eyes, Ears, Nose & Throat**
❑	❑	Visual Problems
❑	❑	Eye Irritation/Problems
❑	❑	Pain in the Eyes
❑	❑	Difficulty Hearing/Deaf
❑	❑	Ringing in the Ears/Dizziness
❑	❑	Ear Growths/Discharge
❑	❑	Ear Pain
❑	❑	Nosebleeds
❑	❑	Change in Ability to Smell
❑	❑	Chronic Sneezing
❑	❑	Nose Growths/Discharge
❑	❑	Nose Pain
❑	❑	Sinusitis
❑	❑	Hoarseness
❑	❑	Change in Voice
❑	❑	Difficulty Swallowing
❑	❑	Enlarged/Painful Glands
❑	❑	Change in Ability to Taste
❑	❑	Dental Problems
❑	❑	Growths/Lesions in Mouth
❑	❑	Growths/Lesions in Throat
P	**C**	**Gastro-Intestinal System**
❑	❑	Change in Appetite
❑	❑	Food Intolerance
❑	❑	Nausea/Vomiting
❑	❑	Vomiting of Blood
❑	❑	Peptic Ulcer
❑	❑	Indigestion/Heartburn
❑	❑	Abdominal Pain
❑	❑	Abdominal Swelling
❑	❑	Gas
❑	❑	Change in Stools (color, etc.)
❑	❑	Diarrhea/Constipation
❑	❑	Hernia
❑	❑	Hemorrhoids
❑	❑	Gallbladder Problems
❑	❑	Liver Disease
❑	❑	Pancreatitis

❑	❑	Alcohol Intake (#Years ______)
		Type _________________
		Amount _________________
P	**C**	**Respiratory System**
❑	❑	Difficulty Breathing
❑	❑	Cough
❑	❑	Blood in Sputum
❑	❑	Wheezing/Asthma
❑	❑	Tuberculosis/Exposure
❑	❑	Pneumonia/Lung Infections
❑	❑	Cigarette Smoking
		#Years _______ #Daily _______
❑	❑	Other Tobacco Use
		❑ Cigar ❑ Pipe ❑ Chewing
		#Years ______ Amount _______
❑	❑	Environmental Toxin Exposure
P	**C**	**Cardio-Vascular System**
❑	❑	Shortness of Breath
❑	❑	Chest Discomfort/Pain
❑	❑	Palpitations
❑	❑	Edema/Swelling
❑	❑	Fainting/Dizziness
❑	❑	Calf Pain while Walking
❑	❑	High Blood Pressure
❑	❑	Heart Disease
❑	❑	Rheumatic Fever
❑	❑	Cardiovascular Surgeries
❑	❑	Cardiac Pacemaker
P	**C**	**Urinary System**
❑	❑	Frequent Urination
❑	❑	Painful Urination
❑	❑	Change in Urine (color, etc.)
❑	❑	Difficulty Starting
❑	❑	Difficulty Holding
❑	❑	Discharge
❑	❑	Urinary Tract Infections
❑	❑	Kidney Disease
❑	❑	Flank Pain
❑	❑	Pelvic Pain
❑	❑	Pelvic Mass
P	**C**	**Breasts**
❑	❑	Bumps/Lumps/Masses
❑	❑	Pain/Tenderness
❑	❑	Dimples in Breast
❑	❑	Change in Color/Size/Shape
❑	❑	Nipple Discharge
P	**C**	**Reproductive System**
❑	❑	Genital Lesions/Sores
❑	❑	Genital Mass/Growth/Pain
❑	❑	Syphilis
❑	❑	Problems with Prostate
		Last Prostate Exam _________
❑	❑	Gonorrhea
❑	❑	Change in Sex Drive
❑	❑	Pain During Sex
❑	❑	Birth Control
		Method _________________
		How Long _________________
❑	❑	Breast/Penile Implants
P	**C**	**Skin, Hair, Nails**
❑	❑	Change in Skin Temperature
❑	❑	Change in Skin Texture
❑	❑	Skin Dryness/Wetness
❑	❑	Skin Discoloration

❑	❑	Rashes/Itching/Sores
❑	❑	Skin Growths
❑	❑	Mole Changes
❑	❑	Skin Pain
❑	❑	Skin Cancer
❑	❑	Change in Hair (texture, etc.)
❑	❑	Hair Growth/Loss
❑	❑	Change in Shape of Nails
❑	❑	Change in Color of Nails
P	**C**	**Neurological System**
❑	❑	Headaches
❑	❑	Epileptic Seizures
❑	❑	Tics/Spasms
❑	❑	Sensory Disturbances
❑	❑	Unusual Weakness
❑	❑	Head Trauma
❑	❑	Stroke
P	**C**	**Musculoskeletal System**
❑	❑	Joint Stiffness
❑	❑	Joint Pain
❑	❑	Joint Swelling
❑	❑	Muscle Cramps
❑	❑	Muscle Weakness
❑	❑	Muscle Wasting
❑	❑	Neck Pain
❑	❑	Mid Back Pain
❑	❑	Low Back Pain
❑	❑	Sacroiliac Pain
❑	❑	Tailbone Pain
❑	❑	Arm Problem
❑	❑	Leg Problem
❑	❑	Fractures
❑	❑	Dislocations/Sprains/Strains
P	**C**	**Psychological History**
❑	❑	Anxiety
❑	❑	Depression
❑	❑	Hospitalization/Therapy
P	**C**	**Medical Treatment**
❑	❑	Hospitalizations Not Listed
❑	❑	Medical Procedures Not Listed
❑	❑	Use of Medication
P	**C**	**Nutrition**
❑	❑	Unusual Appetite
❑	❑	Eat Sporadically
❑	❑	Eat Late at Night
❑	❑	Eat Junk Food
❑	❑	On Special Diet
❑	❑	Vegetarian
		How Long _________________
❑	❑	Taking Supplements
P	**C**	**Females Only**
		Age of 1st Period _____________
		1st Day of Last Cycle ________
		Date of Last PAP Test ________
❑	❑	Premenstrual Syndrome (PMS)
❑	❑	Irregular Cycle
❑	❑	Menstrual Cramping/Pain
		Number of Pregnancies ______
		Number of Children ______
❑	❑	Difficult Deliveries
❑	❑	Hysterectomy (Date ________)
❑	❑	Post Menopausal
		Onset of Menopause _________
❑	❑	Post Menopausal Bleeding

Patient Signature ___________________________________ Date _____________

Dr. Steven Rottell, D.C.

Patient Name (Print)__________________________________ **Date**______________

Please mark the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain: using the appropriate symbols:

D = Dull　　**S** = Stabbing/Cutting　　**B** = Burning
N = Numb　　**T** = Tingling (Pins and Needles)　　**C** = Cramping

On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pian you have right **now**:

No Pain　　Unbearable Pain

|---|

Rate your pain at its **best** (least) in the past week:

No Pain　　Unbearable Pain

|---|

Rate your **average** pain int the past week:

No Pain　　Unbearable Pain

|---|

Rate your **worst** pain in the past week:

No Pain　　Unbearable Pain

|---|

Date: _________________ Signature: ____

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the *overall* impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES**. A score of 0 means no disability at all and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by you pain.

---

1. Family/Home Responsibilities. This category refers to activities related to the home of family. It includes chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving children to school)

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Completely unable to function

2. Recreation. This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Completely unable to function

3. Social Activities. This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Completely unable to function

4. Occupation. This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Completely unable to function

5. Self Care. This category includes activities which involve personal maintenance and independent living (e.g. taking a shower, getting dressed, driving, etc.)

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Completely unable to function

6. Life Support Activity This category refers to basic life support behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Completely unable to function

TOTAL SCORE:______ SIGNATURE:__________________________ DATE:______________

Dr. Steven Rottell, D.C.
2718 Telegraph Ave., Suite 103
Berkeley, CA 94795
510-205-5442

Protecting the Confidentiality of your Health Information

This form is to inform you that we take the Federal HIPAA laws (Health Insurance Portability and Accountability Act of 1996) seriously. Your personal health history will not be made available to others outside our office without your permission.

With the advent of the information age and the rapid dissemination of information, the government has appropriately sought to standardize and protect the privacy of your health information. We have reviewed our procedures regarding your health records and we do our best to protect your privacy at all times and to comply with the provisions of HIPAA. Our office is subject to both State and Federal law regarding the confidentiality of your health information, and in keeping with these laws, we want you to understand our procedures and your rights as one of our valued patients.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment, and conduction health care operations. Your health care information will not be used for other purposes unless we have asked for and been voluntarily given your permission. If you have any questions please contact the office.

______________________________ ______________________
Signature Date

Dr. Steven Rottell, D.C.
2718 Telegraph Ave., Suite 103
Berkeley, CA 94795
510-205-5442

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

Your protected health information -

- is accessed and used for healthcare and related purposes only
- is never sold, rented, transferred, exchanged, and/or used for non-healthcare realted purposes without your written authorization
- is disclosed to third party entities without your written authorization for the purpose of treatment, to obtain payment, and for healthcare operations.

Certain Circumstances

Your protected healthcare information can be disclosed without your written authorization in certain limited circumstances -

- Medical emergencies
- in situations required by law
- with individuals involved in your care
- when requested by a public health agency
- when requested by a law enforcement agency

For purposes other than treatment, obtaining payment, healthcare operations, and certain circumstances, we will ask for your written authorization before using or disclosing your protected healthcare information. If you chose to sign an authorizaton to disclose protected healthcare information, you can revoke that authorization in writing at any time.

Patient Rights

You have the right to request -

- in writing to inspect and/or receive a copy of your health information *
- an alternate means or location to receive health related communications
- in writing to amend, correct, or delete any recorded health information within your possession *
- in writing to restrict some of the uses ad disclosures of your health information *
- in writing an accounting of certain disclosures of your health information made by this office*

* Conditions and limitations may apply; obtain additional information from the office.

We reserve the right to change privacy practices and conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy sent to you.

____________________________ Signature   ____________________ Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

Dr. Steven Rottell, D.C.
2718 Telegraph Ave., Suite 103
Berkeley, CA 94795

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or the patient named below for whom I am legally responsible) by the doctor of chiropractic named below (at any location) and/or other licensed doctors of chiropractic who are now or in the future employed at the clinic or office listed above.

I have had the opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, that in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon all factors then known, is in my best interest.

I have read, or have been read to me, the above consent. I have also had the opportunity to ask questions about this document content and, by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my current condition and for any future condition(s) for which I seek treatment from the below named doctor or in the above named office.

ASK ANY QUESTIONS YOU MAY HAVE REGARDING THIS DOCUMENT BEFORE SIGNING

________________________________ **Patient Name**

________________________________ **Patient Signature**

________________________________ **Patient 's Representative**

________________________________ **Relationship to Patient**

________________________________ **Date Signed**

Dr. Steven Rottell, D.C.
CA License #30928