



WELCOME TO OUR CLINIC. WE SPECIALIZE IN ASSISTING OUR PATIENTS TO ACHIEVE THEIR HIGHEST LEVEL OF HEALTH THROUGH OUR SPINAL AND POSTURAL CORRECTIVE PROGRAMS. OUR APPROACH IS VERY UNIQUE AND ADVANCED FROM OTHER REHABILITATIVE PROGRAMS. THIS ALLOWS OUR PATIENTS TO ACHIEVE FAR SUPERIOR RESULTS COMPARED TO MOST OTHER SYSTEMS.

PLEASE FILL OUT THE FOLLOWING INFORMATION THOROUGHLY SO THE DOCTOR CAN LET YOU KNOW IF YOU ARE A CASE WE CAN ACCEPT. PLEASE FEEL FREE TO ASK ANY QUESTIONS IF YOU NEED ASSISTANCE. WE LOOK FORWARD TO SERVING YOU.

DR. HESSAM KHATAMI

CHIROPRACTIC PHYSICIAN

7815 NW Beacon Sq. Blvd.
Suite 101
BOCA RATON, FL 33487



PHONE: (561) 455-4850

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Patient Consent

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY
OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____ hereby states that by signing this Consent, I acknowledge and agree as follows:

- 1 The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. the Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
- 2 The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
- 3 I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.
- 4 The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the the Practice to conduct its specific health care operations.
- 5 I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operataions. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
- 6 I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
- 7 I understand that if I revoke this consent at any time, the Practice had the right to refuse to treat me.
- 8 I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Patient/Individual (Please Print)

Signature of Patient/Individual

Date Signed

Witness

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APPOINTMENT CANCELLATION POLICY

Time has been specifically reserved for your appointment, procedure, or treatment. Please call at least 24 hours ahead of time if you must cancel an appointment. There is a \$25 charge if you fail to show up for a scheduled appointment or cancel with less than 24 hours notice.

Name of Patient / Individual (Please Print)

Signature of Patient / Individual

Date Signed

Witness

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ Date: _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ male female

Address: _____

Marital status

S	M	W	D	SEP
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Phone #: home: _____ work: _____

E-mail address: _____

Occupation: _____ Employer: _____

Mark (c) for current problems, check O and indicate the age when you had any of the following:

General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleed
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

Genitourinary

- Bed-wetting
 - Bladder infection
 - Blood in urine
 - Kidney infection
 - Kidney stones
 - Prostate trouble
 - Pus in urine
 - Stress incontinence
- Urination
- Overnight more than twice
 - More than 8x in 24hrs
 - Decreased flow/force
 - Painful urination
 - Urgency to urinate

Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

Women only

- Congested breasts
 - Hot flashes
 - Lumps in breast
 - Menopause
 - Vaginal discharge
- Menstrual flow
- Reg. Irreg. Pain / cramps
- Days of flow: _____ Length of cycle: _____
- Date - 1st day last period: _____
- Are you pregnant? yes, no
- If yes, how many months? _____
- How many children do you have? _____ Birth control method: _____
- Date of last PAP test: _____
- normal, abnormal
- Date of last mamogram: _____
- normal, abnormal

Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Please list any medication you are currently taking and why:

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

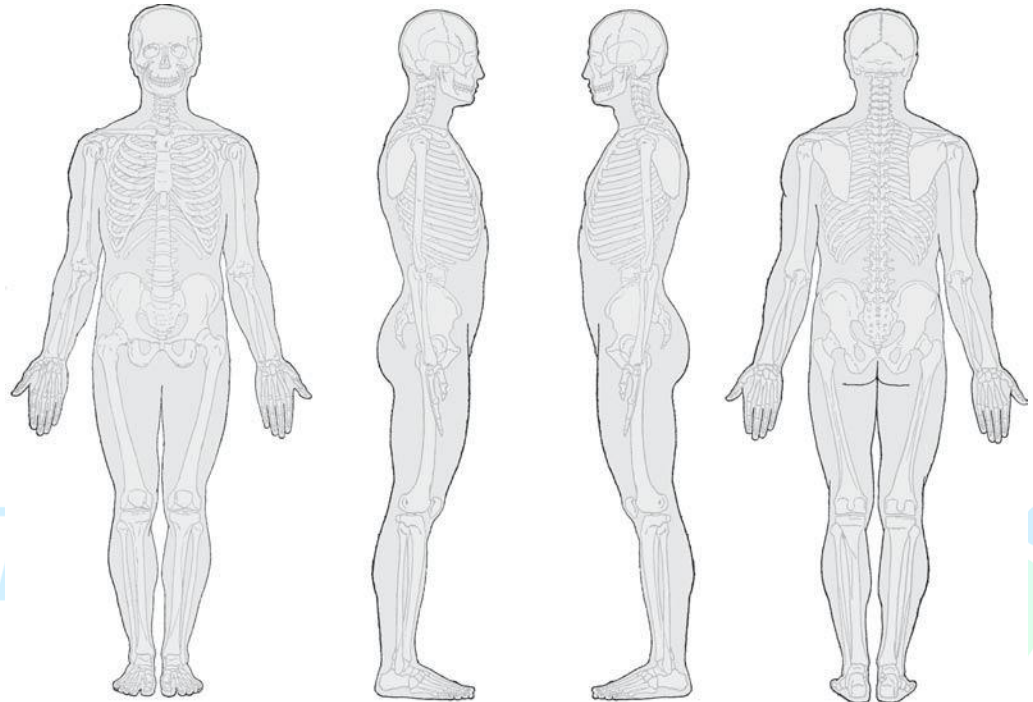
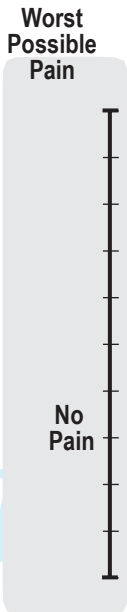
How long have you had this condition? _____ Is it getting worse? yes, no _____

Does it bother you (check appropriate box): work, sleep, other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent?	<input type="checkbox"/> standing, <input type="checkbox"/> sitting, <input type="checkbox"/> other: _____		
How old is your mattress?	_____		
When was your last physical exam?	_____		

Habits	none	light	mod.	heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease |

Do you have any other health issues or concerns that our staff should be made aware of? _____