

# DR. KALANI JOSE, D.C., FICPA

## KALANI CHIROPRACTIC

2100 Outlet Center Drive, Suite 330 • Oxnard, CA 93036

Office (805) 604-0881/2 • Fax (805) 604-0883

### CONFIDENTIAL PATIENT INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City & State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SS#: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

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

Work Address: \_\_\_\_\_ City & State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: **M F** Marital Status: **S M W D**

Spouse's Name & Age: \_\_\_\_\_

Names of Children & Ages: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Have you ever been to a chiropractor before? \_\_\_\_\_ If so, when? \_\_\_\_\_

Circle your complaints and write how long you have had it.

Neck Pain/Stiffness	_____	Rib Problems	_____
Headaches	_____	Low back Pain	_____
Shoulder Pain	_____	Hip/Groin Pain	_____
Arm/Hand Pain	_____	Leg Pain (R/L)	_____
High/Low Blood Pressure	_____	Dizziness	_____
Allergies	_____	Upper/Mid Back Pain	_____

What type of care have you already received for your condition?

Chiropractic \_\_\_\_\_ Massage \_\_\_\_\_ Medication \_\_\_\_\_ Surgery \_\_\_\_\_ Other \_\_\_\_\_

Name of Doctor(s) who have cared for you: \_\_\_\_\_

Circle any conditions you have currently or previously had.

AIDS/HIV	Arthritis	Asthma	Anemia	Anorexia
Appendicitis	Bulimia	Cancer	Bleeding	Breast Lump
Bronchitis	Diabetes	Emphysema	Cataracts	Chemical Dependand
Chicken Pox	Goiter	Gonorrhea	Epilepsy	Fractures
Glaucoma	Hernia	Herniated Disc	Gout	Heart Disease
Hepatitis	Liver Disease	Measles	Herpes	High Cholesterol
Kidney Disease	MS	Mumps	Osteoporosis	Miscarriage
Mono	Pinched Nerve	Pneumonia	Polio	Pacemaker
Parkinson's	Psychiatric Care	Rheumatoid Arthritis	Rheumatic Fever	Prostate Problem
Stroke	Suicide Attempt	Thyroid Problems	Tonsillitis	Scarlet Fever
Tumors, growths	Typhoid Fever	Ulcers	Vaginal Infections	Vision Problems
Fibromyalgia	Migraine	Cold/Flu	Viral Infections	TB
Whooping Cough	Vision Problems	Ear Infections	Other _____	

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The vast majority of our patients have been involved in dozens of **IMPACTS** that could cause **VERTEBRAL SUBLUXATION** (spinal misalignments); Kalani Chiropractic wants to discover 5 of yours.

1. When was your MOST recent **Auto/Motorcycle Accident**, even as a passenger? Date: \_\_\_\_\_  
Circle: Major / Minor Impact What body part did you injure? \_\_\_\_\_ Treatment: Medical / Chiropractic
  
2. When was the accident before that? Date: \_\_\_\_\_  
Circle: Major / Minor Impact What body part did you injure? \_\_\_\_\_ Treatment: Medical / Chiropractic

**Most people have a slip, strain, twist or fall playing sports, at home or at work, whether it was reported or not.**

1. When was your most recent injury? Date: \_\_\_\_\_  
Describe: \_\_\_\_\_  
What body part did you injure? \_\_\_\_\_ Treatment: Medical / Chiropractic
  
2. When was your most recent injury? Date: \_\_\_\_\_  
Describe: \_\_\_\_\_  
What body part did you injure? \_\_\_\_\_ Treatment: Medical / Chiropractic
  
3. When was your most recent injury? Date: \_\_\_\_\_  
Describe: \_\_\_\_\_  
What body part did you injure? \_\_\_\_\_ Treatment: Medical / Chiropractic

**Please list any surgeries, traumas, fractures, etc. that have not been mentioned above.**

- Date: \_\_\_\_\_ Describe/Treatment: \_\_\_\_\_
- Date: \_\_\_\_\_ Describe/Treatment: \_\_\_\_\_
- Date: \_\_\_\_\_ Describe/Treatment: \_\_\_\_\_
- Date: \_\_\_\_\_ Describe/Treatment: \_\_\_\_\_

Exercise	Work Activity	Habits
None	Sitting _____ Hrs/Day	Smoking Packs/Day _____
Moderate	Standing _____ Hrs/Day	Alcohol Drinks/Week _____
Daily	Light. labor _____ Hrs/Day	Coffee/Caffeine Cups/Day _____
Extreme Sports	Heavy. Labor _____ Hrs/Day	High Stress Level Reason _____
Weight Lifting	Other _____	_____
Other: _____	_____	Other _____

**For Women Only:** Are you pregnant? Yes No Due Date \_\_\_\_\_ Last menstrual period \_\_\_\_\_

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## Medications/Vitamins/Herbs/Minerals

Please list all meds, vitamins, and supplements currently: \_\_\_\_\_  
\_\_\_\_\_

**Goal Question: If you could accomplish one important thing or mission for your life, what would that be?**

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**PRIMARY INSURANCE:** (Group \_\_\_\_\_ Work Comp \_\_\_\_\_ Auto \_\_\_\_\_ Other \_\_\_\_\_)  
Insurance Co.: \_\_\_\_\_ Name of *Insured*: \_\_\_\_\_  
Claim # or Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED THE FEE PAID FOR TREATMENT X-RAYS IS FOR ANALYSIS ONLY. THE FILMS ITSELF IS THE PROPERTY OF THIS OFFICE. ONCE FILMS ARE USED FOR TREATMENT PURPOSES, THEY CANNOT BE RELEASE WITHOUT PROPER WRITTEN REQUEST.
2. Method of payment you plan to use for today's services:  
Cash \_\_\_\_\_ Check \_\_\_\_\_ Charge \_\_\_\_\_
3. I hereby authorize the doctor, and/or his associates to examine me, and to perform any necessary diagnostic procedures, including x-rays to fully evaluate my condition for the presence of vertebral subluxation.
4. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Kalani Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian (*if under 18*) Signature for  
Authorized Care: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Minor: \_\_\_\_\_

In Case of Emergency notify: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone \_\_\_\_\_

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## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we will accept patient for such care, it is essential for both to be working towards the same objective.

**Chiropractic** has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the  
(print name)  
above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore, I accept chiropractic care on this basis.

\_\_\_\_\_  
**Signature**

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

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## Informed Consent to Chiropractic Care

***Patient:** Please discuss any questions or concerns with the doctor before signing this consent.*

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 below named minor in which I am legally responsible for) by Dr. Kalani G. Jose, his staff, and/or his associates.

### **The Nature of The Chiropractic Adjustment**

I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “pop” your knuckles. You may feel a sense of movement.

### **The Material Risks Inherent with The Chiropractic Adjustment**

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

### **The Probability of Those Risks Occurring**

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, we look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as “rare”.

### **Ancillary Treatment**

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

- Heat ~ risk of 1<sup>st</sup> and 2<sup>nd</sup> degree burns, hemorrhage
- Cryotherapy (cold packs) ~ risk of skin reactions
- Trigger Point Therapy ~ risk of bruising, release of emboli
- Massage ~ risk of deep vein thrombosis

### **The Availability and Nature of Other Treatment Options**

- Other treatment options for your condition may include:
- Self-administered over-the-counter analgesics and rest
  - Medical care with prescription drugs
  - Hospitalization
  - Surgery

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## The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

## The Risks and Dangers Attendant To Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had all my questions answered to my satisfaction. 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 (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient

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**Patient Acknowledgement of Privacy**

**I acknowledge that I have read and fully understand the the Notice of Privacy Practices of Kalani Chiropractic. I understand that I may request a copy of this notice at any time. I further understand that this Notice may be modified with no prior notification to me.**

\_\_\_\_\_  
Print Full Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative (If signing for a minor I have authority to do so)