Heal From Within

1032 South Alamo Street San Antonio, TX. 78210 210-927-2095

CHIROPRACTIC CASE HISTORY

Reason for your visit (Circle): **Chiropractic** **Nutrition** **Orthotics**

Date _____ Name_____ Gender: M F Marital Status: S M D (other)

Address_____ City_____ State_____Zip. _____

H.Phone (____)_____ Cell (____)_____ Email_____

Date of Birth_____Age _____ Occupation_____ Employer_____

Have you ever received Chiropractic Care? Yes No If yes when & why?_____

In Case of Emergency: (____) _____ Name:_____ Relationship_____

1. Primary reasons for seeking chiropractic care:_____

Complaint(s) began when and how: _____

The above condition(s) is/are due to Auto Accident: YES NO Work Related Injury: YES NO

Severity of Pain: Please Circle **0 1 2 3 4 5 6 7 8 9 10**

(No pain) (Mild Pain) (Severe pain)

Circle the Quality of the complaints/pain: Burning Deep Dull Nagging Numbness Sharp Stabbing Throbbing Tingling

Does this complaint/pain radiate or travel (shoot) to any areas of your body? YES NO Where?_____

Do you have any numbness/tingling in your body? YES NO Where?_____

How frequent is complaint present, how long does it last?_____

Does anything aggravate the condition? Yes or No: _____

Does anything make the complaint better? Yes or No: Explain _____ Do you have pain in your feet? Yes or No

2. Previous interventions, treatments, medications, surgeries, or care you've sought for your complaint (list any OTC medications here) :_____

_____

3. Past Health History:

A. Previous injury or trauma_____

Have you broken any bones? Which ones? _____

B. Previous/current illnesses: (i.e., diabetes, high blood pressure, cholesterol)_____

C. Do you have allergies /arthritis: _____

D. Medications/Vitamins You Are Currently Taking:

Medication(s) / Vitamin(s) : _____ Reason(s) for taking _____

_____ _____

E. Surgeries You Have Had

Date _____ Type of Surgery _____

_____ _____

F. **FEMALES ONLY**: Pregnancies / Outcomes

Pregnancies / Date of Delivery _____ Outcome _____

_____ _____

Date of the beginning of your last menstrual period? _____ Are you Pregnant now? YES NO

4. Family Health History:

Associated health problems of relatives (circle):

Mother: Cancer Heart Diabetes Other _____ Father: Cancer Heart Diabetes Other _____

Sibling (1): Cancer Heart Diabetes Other _____ Sibling (2): Cancer Heart Diabetes Other _____

5. Social and Occupational History:

Level of Education: ( ) High School ( ) Some College ( ) College Graduate ( ) Post Graduate Studies

Job description: _____ Work Schedule:_____

Lifestyle/Exercise Routine (including tobacco and/or drug use): _____

How is your diet? ***(Circle)*** Healthy Healthy Sometimes Fast-Food

COMPREHENSIVE MEDICAL HISTORY: I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature _____Date_____

(a.) ***Patient Read and Affirm Informed Consent to Chiropractic Adjustments & Care*** _____ Patient Initials

(b.) Office Policy on Appointments: In order to better serve our patients, we schedule appointments in advance. If you are unable to keep your scheduled appointment, we ask that you cancel it at least one (1) day in advance. If you are running late, please contact us to let us know to see if that be accommodated. We may need to reschedule your appointment. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. If you do not contact us as stated above, you will be charged a **$25 missed appointment fee for appointments -Tuesday through Friday, and $50 on Saturday.** Patient Initials _____

(c.) Would you like to receive emails from the office regarding new events/products? _____ Patient Initials

14-POINT REVIEW OF SYSTEMS

PLEASE CIRCLE CURRENT SYMPTOMS

PATIENT NAME:_____ DOB:_____

CONSTITUTIONAL: Fever Night Sweats Chills Fatigue Weight Gain/Loss Changes In Appetite

EYES: Change In Vision Loss Of Vision Blurred Vision Double Vision Glasses

EARS: Difficulty Hearing Hearing Loss Hearing Aids

NOSE: Nasal Congestion Nasal Discharge

MOUTH/THROAT/VOICE: Dentures Lip Sores Mouth Sores Tongue Sores Sore Throat

HEAD/NECK: Neck Pain Neck Stiffness

SKIN: Rash Lesion Nails Bruising Itching

RESPIRATORY: Cough Wheezing Shortness of breath when lying down Difficulty Breathing Waking up from sleep gasping for air

CARDIOVASCULAR: Chest Pain Palpitations Passing Out Lower Extremity Edema

GASTROINTESTINAL/GENITOURINARY: Abdominal Pain Nausea Constipation

MUSCULOSKELTAL: Muscle Pain Back Pain Muscle Cramps Joint Pain

NEUROLOGICAL: Headaches Light Headedness Dizziness Weakness On One Side

PSYCHIATRIC: Sleep Disturbances Anxiety Depression Thoughts of Suicide

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information - Your Protected Health Information will be used by **SANA Wellness & Health, LLC** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices - You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information - You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent - You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice - This office reserves the right to modify the privacy practices outlined in the Notice.

Signature - I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it. I am aware these offices DOES NOT have open therapy areas.

Name of Patient (print)	**Signature of Patient**	**Date**

Signature of Patient Representative Representative	Date	Relationship of Patient

Others we may release your PHI to

Brenda Hernandez	01/01/2021
Office Representative	**Date**

ACKNOWLEDGEMENT FORM

SANA Wellness & Health, LLC
Suhail Daraiseh, D.C.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that SANA Wellness & Health, LLC "Notice of Privacy Practices" has been provided to me.

I understand that I have the right to review SANA Wellness & Health's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for SANA Wellness & Health is also provided on request at the front desk of the practice. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information what will occur in my treatment, payment of my bills or in performance of health care operations of SANA Wellness & Health, LLC. This Notice of Privacy Practices also describes my rights and SANA Wellness & Health's duties with respect to my protected health information.

SANA Wellness & Health, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.

Signature of Patient or Personal Representative	Name of Patient or Personal Representative	Date

Brenda Hernandez, SANA Wellness & Health, LLC, Office Representative