Nutrition Intake Form

Please Print Clearly

Last Name: _____ First Name: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____)_____ E-mail Address: _____@_____

Occupation: _____ Employer: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Referred by: _____

Current Complaints (reason that you are here):

_____

_____

Current and past medications/drugs (and dosages):

_____

_____

_____

Past surgeries you have had and your age at the time of surgery:

_____

_____

_____

_____

Are you currently under the care of a physician or other health care professional? If yes, please provide name:

_____

Are you currently taking vitamins, herbs, or nutritional supplements? If yes, please list:

_____

_____

Personal Habits (Please circle all that apply):

Cigarettes _____Coffee _____ Alcohol _____Soda_____ Sugar _____Non prescription drugs_____

Do you consider yourself (Circle): Overweight Average Underweight

Describe activity level (Circle): Sedentary Light Moderate Heavy

Are you primarily responsible for preparing your own meals?(Circle): Yes No

How many of your weekly meals do you eat out? _____

How many glasses of water do you drink each day? _____

List any foods you crave:

_____

_____

_____

List any foods you avoid:

_____

_____

_____

List any special diet or dietary restrictions:

_____

_____

Are you following a dietary regimen (Weight Watchers, etc.) Yes No

Family History (Immediate family only):

_____

_____

_____

_____

Patient Signature: _____ Date: _____

PERSONAL HISTORY-please print clearly

Last Name: _____ First Name: _____ Middle Initial:_____

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

Cell Phone:_____ Home Phone:_____ Birthdate: _____ Age:_____

Employer Name:_____ Job Title:_____ Email:_____

Job Function (eg :sitting/standing/walking/bending/lifting etc)_____ # Hours at computer_____

Circle One: Married Single Divorced Widowed # of children_____

How did you hear about Dr. Bahar? Patient_____ Other _____

Have you had previous chiropractic care? Yes No When?_____ Name of Chiropractor_____

What are your hobbies/activites/exercises?_____

CURRENT HEALTH CONDITION

What is your Condition/Symptom (Describe)	Onset Gradual or Sudden? When?	What makes it better/worse?	How have you been treating? Eg: medications therapies	Pain Level at worst 1-10 (10 being worst	Pain Level at best 1-10 (1 being no pain)	

CURRENT MEDICATIONS (list prescription, non-prescription, vitamins, supplements)

Medication Name (current)	Dosage	Frequency

Medication Allergies	Reaction	Onset Date

Below is a list of conditions which may seem unrelated to the purpose of you appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis and treatment

__Headache/Migraines __Fatigue __Chest Pain/Shortness of breath __Diarrhea/Constipation

__Dizziness __Insomnia __Heart Palpitations/Murmur __Excess Gas

__Ear Infections __Loss of Memory __Stomach/Digestive Problems __Freq. Urination/UTI

__Sinus Problems __Cold/Burning/Itchy Hands __Asthma/Upper Resp Infection __Pain/Numb/Tingling down legs

__Allergies/Asthma __Depression/Anxiety __Bronchitis/Pneumonia __Cramping toes/feet/legs

__Blurry vision/eye pain __Thyroid Condition __Heartburn/Indigestion __Impotence/Infertility

__Sore Throats __Anxiety __Gassy/Bloating __Irregular Periods/Menstrual cramps

__Hi/Lo Blood pressure __Numb/tingling arms/fingers __Gallbladder problems __Hemorrhoids

	Never	Daily	Weekly	Occasionally
Alcohol				
Diet Food Products				
Processed Foods				
Homemade Foods				
Soft Drinks				
Water				
Caffeine				
Drugs				
Tobacco				
Exercise				

HEALTH HISTORY

PRIOR ILLNESS/SURGERY/HOSPITALIZATIONS/ACCIDENTS	DATE (or at what age?

WHAT IS YOUR FAMILY HISTORY (immediate family only)

Family Member	High Blood Pressure	Diabetes	Cancer (Describe type)	Alcohol	

INSURANCE

Health Insurance Co. Name_____ We will take a copy of your insurance card.

Policy Holder Name_____ Birth Date:_____

Patient Signature_____Date_____

PROVIDER PRIVACY POLICY

Century Chiropractic Center is required, by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.
PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be disclosed to other health care professionals for the purpose of evaluating your health and providing treatment. For example, customer service information may be available to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the daily operation and management of Supplier. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to assist in government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other that those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights. You have certain rights under the federal privacy standards. These include:

*The right to request restrictions on the use and disclosure of your protected health information
*The right to receive confidential communications concerning your medical condition and treatment
*The right to inspect and copy your protected health information
*The right to amend or submit corrections to your protected health information
*The right to receive an accounting of how and to whom your protected health information has been disclosed
*The right to receive a printed copy of this notice

Supplier's Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applies to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Century Chiropractic Center. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Century Chiropractic Center
3151 Olin Ave. Suite #100
San Jose, CA 95117

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is:

Bahar Nehawandian, DC
3151 Olin Ave. Suite #100
San Jose, CA 95117
408-261-2222

Effective Date

This notice is effective on or after January 1, 2009

The undersigned below hereby acknowledges that he/she has read and understood the policies of the Supplier

_____ _____

Signature Date

_____

Printed Name

CENTURY CHIROPRACTIC CENTER

3151 Olin Ave. #100
San Jose, CA 95117
408-261-2222

Professional Fee Schedule- Bahar Nehawandian, DC

Chiropractic Exam	$150-$225
Chiropractic Office Visit/Adjustment	$70-$120
Extra Spinal Adjusting	$38
Chiropractic X-ray Studies	$75-$150
Re-evaluation Exam	$150-$225
Missed Appointment Fee	$28
Nutrition Initial Consultation	$150
Nutritional Follow-Up	$65

Therapeutic Exercises	$68-$70
Myofascial Release/Therapy	$65
Muscle Stim	$35
Flexion/Traction	$35
Heat/Ice	$12
Ultrasound Therapy	$27
30 min Massage	$50
60 min Massage	$85
90 min Massage	$135
Missed/Late Cancel fee is 50% of scheduled appt cost	

Please read the following and choose which financial situation best identifies your situation.

_____**HEALTH INSURANCE:** If you have insurance that covers Chiropractic care, we can bill your insurance directly. Please provide us with a completed insurance claim form and a copy of your insurance ID card. Until we have verified the policy and chiropractic care coverage, you will be responsible for 100% of all charges. Once verification is complete, you will be responsible for any deductible and co-pay amount stated in your plan at the time services are rendered. Please note that most insurance plans do not pay for "maintenance care" and long term rehabilitation. Note that each plan offers exceptions. Most health care plans cover acute problems so you may have to cover your payments once you have overcome acute care or have reached maximum allowable visits or annual dollar allotments.

PATIENT'S OR AUTHORIZED SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below:
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

_____**CASH:** Payment is expected at time professional services are rendered. Payments can be made by cash, check, Visa, or Mastercard. Certain discounts are allowable with pre-paid plans.

_____**WORKERS COMPENSATION:** If you have been injured at work, please notify us immediately. State regulations apply. You must report your accident to your employer before receiving treatment in our office.

_____**MEDICARE:** Our office is a Participating Provider with the Medicare Program. Patient is responsible for co-pay and annual deductible if secondary insurance (Part B) does not cover.

_____**AUTO ACCIDENT INJURY:** Please supply us with a copy of the accident report (if any), your health insurance card, proof of auto insurance, and liable parties insurance, if applicable. There are four methods of payment if you have been involved in an auto accident:

_____**MEDPAY:** Medpay is a no-fault medical insurance that will pay your medical bills immediately. This coverage is provided through your auto policy, or the policy of the car you were in at the time of the accident. Medpay is usually 100% coverage. Please note that if you were <u>not</u> at fault, your insurance rates cannot be raised if you use your Medpay benefits in accordance with California law.

_____**HEALTH INSURANCE:** We can bill your regular health insurance. They will pay benefits according to your plan. You will be responsible for all deductibles and co-pays at the time of service.

_____**CASH:** Full payment is due at time of service. We will provide you with an itemized statement and report if necessary for reimbursement.

_____**ATTORNEY LIEN:** If you have retained an attorney, and we approve of the attorney, we may extend credit based on a documented and signed lien.

I understand and accept the financial situation I have checked. I also understand that I am personally responsible for all charges regardless of insurance coverage.

Patient Signature: _____ Date: _____

Patient Name (Printed): _____ (effective 1/2/2021)

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able 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 the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name: Bahar Nehawandian , D.C

Signature of Doctor of Chiropractic:_____

Date:_____