CARSON DOCTORS GROUP
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Voice (310) 533-1070 Fax (310) 328-8501
C.M.Wilkerson, D.C.

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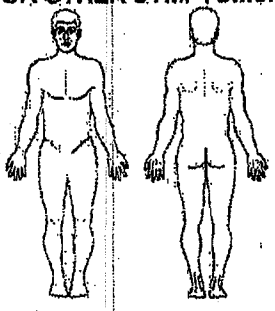
Who referred you to this office? _____
What is the name, phone and fax of your regular family doctor? _____
What is your email? _____@_____
Your height: _____ Weight: _____

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
_____
_____
_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%
Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____
WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, # of births _____
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (date) _____	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Surgeries/Medications: _____
☐	☐	Cancer/Tumor			_____
☐	☐	Osteoporosis			_____
☐	☐	Recent Trauma			

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____

CARSON CHIROPRACTIC/CARSON DOCTORS GROUP

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Carson Chiropractic is required by law to protect your health information for privacy and confidentiality. Please read it carefully. All doctors office are bound by HIPAA rules, hence this document.

We May disclose your health information regarding:

Treatment- to other healthcare professionals within our practice

Payment- to insurance companies regarding payment or health care operations.

Workers Compensation- to comply with State Workers' Compensation Laws

Emergencies- to notify or assist your family/responsible person in case of injury or death.

Public Health- to public authorities for purposes of preventing/controlling disease, child abuse, reactions to medicines, and reporting disease or infection, for example.

Judicial and Administration Proceedings-

Law Enforcement- to identify a fugitive, material witness or missing person subpoenas.

Deceased Persons- to coroners or medical examiners

Organ Donation- to organizations that procure, bank, or transplant organs and tissues

Research- to researchers for research approved by an Institutional Review Board.

Public Safety- to persons preventing imminent threat to the public's health or safety.

Specialized Government Agencies- to military, national security, prisoner and Gov. Benefits purposes.

Marketing- we may contact you for fundraising or marketing purposes.

Change of Ownership of this practice- to mergers or new owners

Your Health Information Rights- you may review your health info, request restrictions and disclosures, have alternative communication methods of your information, can amend your health information, receive full accounting of health info, and have a paper copy of this document after signature. Carson Chiropractic Corp can deny or not amend upon your request via a formal explanation.

Changes to this Notice of Privacy Practices- Carson Chiropractic/Doctors Group can amend this document. If you have questions regarding anything in this document you can contact the Office Manager at 562-439-0419 or make a personal appointment within 2 working days..

Complaints- address the Office Manager or make a personal appointment within 2 days.

Further complaints can be directed to DHHS, Office of Civil Rights, 200 Independence Ave, S.W., Room 509F HHH Bldg, Washington, DC 20201

I have read the Privacy Notice and understand my rights and authorize Carson Chiropractic to use and disclose my protected health care information for treatment, payment, and healthcare operations as described above.

Patient's Name (print)	Patient's Signature	cmw Officer Signature

A more thorough explanation of HIPAA is available in the lobby or from the staff. You have 48 hours to review it. If you understand and agree with both documents you need not reply.

INFORMED CONSENT TO TREAT DOCUMENT

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument 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 "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are considering the following procedures:

___Spinal Manipulative Therapy	__Palpation	___Vital Signs
___Range of motion	__Orthopedic test	___Neurological
___Muscle Strength testing	__postural analysis	__hot/cold therapy
___Ultrasound		
__ Electro muscle Stimulation (EMS)		
___Radiographic Study		
___Other (explain) _____		

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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 and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTANDTHE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Wilkerson, and have had my questions answered to my satisfaction.
By signing below, I state that I have weighed the risks involved and undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

Patient's Name: _____ Doctor's Name: _____

Signature: _____ Signature: _____

_____
Signature of Parent or Guardian
(If minor)