# Valley Chiropractic

Dr. Claudia Kindler
Dr. Kaede Fischer

## Registration Form

Patient's Name: Klein (Last) Adam (First) G (MI)

Address: 38 San Jose Ave Unit 2

City: San Francisco State: CA Zip: 94110

Birth Date: 08/09/1998 Sex: ( ) F / (•) M / ( ) X / ( ) Decline to state

Phone: (cell) 3033962747 (home) _____ (work) _____

Email address: agklein98@gmail.com

Preferred Method of Contact: ☑ cell / ☐ home / ☐ work / ☐ email

Occupation: Software Engineer Employer: Amazon

Marital Status: ☑ S / ☐ M / ☐ DP / ☐ W Significant other's name: _____

Have you ever been to a chiropractor before? ☑ Y / ☐ N If yes, when? 2021

Whom may I thank for referring you? Emily O'Neal

**IN CASE OF EMERGENCY:**

Name of contact: Marc Klein

Relationship to patient: Father Phone: 3035850196

The above information is true to the best of my knowledge. I hereby give permission to the doctor to administer treatment and perform such general procedures, as she may deem necessary in the diagnosis and/or treatment of my condition.

I understand that I am financially responsible for the full balance at the time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

Signature Adam Klein Date: 10-18-22

I have read and agree to the above conditions

# Valley Chiropractic
## Patient Consent Form

**Authorization for Care:**

I understand that chiropractic treatment consists of moving joints and soft tissues as well as physical therapy modalities and exercise protocols. Although chiropractic care is considered a safe and effective tool for decreasing pain and improving activities of daily life, I am aware that the benefits are not guaranteed and the following are possible risks:

- Soreness: It is common for people to experience soreness after the first few treatments as the body responds to the new movement and posture.
- Dizziness: Temporary symptoms like dizziness and nausea can occur but are rare.
- Fracture: Patients with weak bones from underlying pathologies may be susceptible to injury.

I understand alternative treatments are available including non-treatment, rest, medication, and surgery, however, these also have associated risks. I have read, or have had read to me, the above consent and have had the opportunity to ask any questions regarding its content.

I, Adam Klein, hereby give my consent for chiropractic examination and treatment and authorize procedures as deemed necessary in the diagnosis and/or treatment of my condition.

Signature: Adam Klein Date: 10-18-22

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**Protected Health Information:**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that personal health care information be kept confidential. We understand the importance of your privacy and will do our best to maintain it.

- Only when it is appropriate or necessary, will we provide information regarding treatment, payment, or health care operations to a third party.
- We support your right to inspect and copy your personal medical records upon written request.
- You have the right to refuse consent or request restrictions on certain uses and disclosures of your health information. If you chose to give your consent, you have the right to revoke it, in writing, at any time.
- You have the right to review our Notice of Privacy Practices and speak with our HIPAA Compliance Officer, Serena Young, regarding questions.

I, Adam Klein, understand my right according to HIPAA and how my personal health care information may be used and disclosed.

Signature: Adam Klein Date: 10-18-22

**Welcome to Valley Chiropractic!**
**Kindly take a moment to familiarize yourself with our office policies and procedures.**

**Payment Policies and Procedures:**

Payment must be made in full at the time services are rendered.

HEALTH INSURANCE: We are an **out of network** provider. As a courtesy, we will gladly submit to your health insurance company for reimbursement to you. Insurance policies can differ greatly in terms of deductible and percentage of coverage. Please contact your insurance company if you have any questions regarding your plan.

PERSONAL INJURY: Depending on your individual circumstance, your auto insurance company may pay us directly for your treatment. If you do not have medical coverage on your car insurance, you will be responsible for payment at the time of service.

**Appointments and Scheduling:**

We make an extra effort to stay on time and ask that you be on time as well.

A new patient visit is approximately 30 minutes in length and costs **$165.00**. A routine office visit is 15 minutes in length and costs **$90.00.**

If you have a new injury while under care, please let us know so we can provide necessary paperwork and schedule accordingly.

**Cancellation and Missed Appointment Policy:**

If you need to cancel your appointment, please do so **24 hours** prior to the time of the appointment to avoid charge. If you cancel without 24 hours' notice, you will be responsible for the appointment fee. IF you miss your appointment, you will be responsible for the appointment fee.

**FINANCIAL RESPONSIBILITY**: I understand and agree that I am personally responsible for my account.

**We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.**

I have read and understood the patient treatment consent policies of Valley Chiropractic.

Adam Klein _____ 10-18-22 _____

Signature Date

Adam Klein _____

Printed Name

**Please mark (x) for all present symptoms and circle (o) all previous symptoms.**
**Additionally, please circle R for Right and L for Left.**

**NAME:** Adam Klein **Height:** 6'0" **Weight:** 190

**HEAD:**
- [o] Headache
- [o] Light-headedness
- [o] Loss of balance
- [ ] Ear ache
- [R] Ringing in ear(s) (R - L) [ ]
- [ ] Pain relieves with: Massage, stretching, Chiropractic care

**NECK:**
- [ ] Neck feels out of place
- [ ] Muscle spasms
- [o] Neck pain with movement
- [o] Neck pain with rest
- [ ] Pain relieves with: Sameasabove

**CHEST:**
- [ ] Chest pain
- [x] Shortness of breath
- [x] Rib pain
- [ ] Breast pain

**ARE YOU:**
- [ ] Left handed
- [x] Right handed

When using a mouse:
- [ ] Left handed
- [x] Right handed

**SHOULDERS/ ARMS/ HANDS:**
- [x] Pain in shoulder joint (R - L) [ ]
- [x] Pain between shoulders
- [ ] Can't raise arm
- [ ] Pain in upper arm
- [ ] Pain in elbow
- [ ] Pain in forearm
- [ ] Pain in hand (s)
- [ ] Sensation of pins & needles
- [ ] Numbness
- [ ] Loss of grip strength
- [ ] Pain relieves with: massage and stretching

**MID-BACK:**
- [ ] feels out of place
- [ ] pain with movement:

**LOW BACK:**
- [ ] Low back feels out of place
- [ ] Low back pain with movement
- [ ] Low back pain with rest
- [ ] Muscle spasms
- [ ] Pain relieves with:

**ABDOMEN:**
- [x] Nervous stomach
- [x] List foods can't eat: So many. I don't think this is related to chiro stuff

**HIPS/ LEGS / FEET:**
- [ ] Pain in buttock(s) (R - L) [ ]
- [ ] Pain in hip joint (R - L) [ ]
- [ ] Pain down leg (R - L) [ ]
- [o] Knee pain
- [ ] Pins & needles in leg(s) (R - L) [ ]
- [ ] Numbness of leg (R - L) [ ]
- [ ] Numbness of foot (R - L) [ ]
- [ ] Pain relieves with:

**WOMEN:**
- [ ] Menstrual cramping
- [ ] Irregularity
- [ ] Menopause
- [ ] Hysterectomy
- [ ] Fibroids
- [ ] Breast Implants
- [ ] Pregnant

**GENERAL:**
- [ ] Change in sleep pattern
- [ ] Gain/loss of weight____ lbs

**DIET:**
- [x] Eat a varied diet
- [x] Water enough cups/day
- [ ] Coffee_____cups/day
- [ ] Tea_____cups/day
  - [ ] caffeinated [ ] herbal
- [ ] Alcohol_____srvgs/day
- [ ] Smoker

**EXERCISE:**
Type : Running
stationary bike
TRX bands light upper body
Frequency: 4-5 times a week

**WHAT POSITION DO YOU SLEEP IN?**
- [x] Back
- [ ] Front (Stomach)
- [x] Side (R - L ) [ ]

**Describe major complaint(s) and symptom(s):** Pain behind below and next to left shoulder blade. Often occurs when I restart upper body excercise. Affects sleeping and occasionally breathing.

**Date you first noticed symptom(s):** 10-11-22

**HAVE YOU:**
- [ ] Been knocked unconscious?
- [ ] Had a recently fractured bone?
- [ ] Used a crutch or other support?
- [ ] Been in an auto accident? If so, when? _____
- [x] Had a surgery?
- [ ] Been treated for a spine or nerve disorder?
- [ ] Been hospitalized for other than surgery?

**PLEASE LIST:**
Medication currently taking: Allergy meds
Known allergies: Seasonal, Ibuprofen
Recent surgeries: Endoscopy

**MARK (x) THE FOLLOWING CONDITIONS YOU HAVE (OR HAD) and CIRCLE (o) ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS:**
- [ ] A.I.D.S.
- [ ] Cancer
- [ ] Diabetes
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Smoking
- [ ] Stroke

Anything else you want to tell the doctor? Regularly use lacrosse ball and stretch areas that bother me. When that doesn't work then I'm pretty sure something is out of alignment.

After reading and filling out the health history, your signature will verify that all the information you have given us is accurate and that you have read the health history questions entirely.

**Signature** Adam Klein **Date:** 10-18-22

# ACTIVITY QUESTIONNAIRE

Patient Name: Adam Klein Date: 10-18-22

Check only the activities below that affect you currently. Be specific and indicate whether your pain, weakness, stiffness or other symptoms annoy you, slow you down, make it difficult or prevent you from performing the activity.

| ACTIVITY DESCRIPTION | ANNOYS ONLY | SLOWS DOWN | HARD TO DO | UNABLE TO DO |
|---|---|---|---|---|
| Bending head downward or upwards | | ✔ | | |
| Working at computer station | | ✔ | | |
| Driving car | | ✔ | | |
| Sitting | ✔ | | | |
| Working at desk | ✔ | | | |
| Lifting/reaching hands over level of shoulder | | | | |
| Lifting/reaching hands over level of head | | | | |
| Lifting at work | | | | |
| Doing reaching activities | | | | |
| Combing/brushing hair | | | | |
| Typing on a keyboard | ✔ | | | |
| Carrying objects in hand | | | | |
| Gripping objects or using wrists or hands | | | | |
| Sleeping | | | ✔ | |
| Recreational/sports/hobby activities | | | | |
| Doing housework or gardening | | | | |
| Stooping/bending | | | | |
| Twisting | | | | |
| Crouching/kneeling | | | | |
| Walking | | | | |
| Standing | | | | |
| Climbing stairs | | | | |
| Running | | | | |
| Pushing/pulling | | | | |
| Lifting at home | | | | |
| Sexual relations | | | | |

## PAIN DRAWING

**Please indicate below the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing:**

Sharp & Stabbing = + + + +
Dull & Achy = V V V V
Pins & Needles = 0 0 0 0
Numbness = ////

(Please click on the images and use the space bar to advance through the diagram) -->