REHL CHIROPRACTIC
ADVANCED HOLISTIC HEALTH CARE

Confidential Patient Record

Today's Date: _____

Personal Info

Name _____ Gender_____Gender at birth_____ Age_____ DOB _____

Address_____ City _____ State_____ Zip _____

Mobile # _____ Home # _____Business #_____

Email_____ Occupation _____

Full Name of Insurance for Superbills (include any "of California") _____

Marital Status MARRIED PARTNERED SINGLE WIDOWED DIVORCED OTHER Spouse/Partner's Name_____

Name and Phone of Emergency Contact _____ Relationship_____

How did you hear about our office? _____

Have you ever been to a chiropractor before? Y N If yes, which doctor?_____

Are any of your close family members currently being treated by us?_____

Pain & Scars

10 **Worst Pain You Can Imagine**
9 **Severe** – Pain is so bad that you can't do any of your regular activities, including talking or sleeping.
8 **Severe** – Pain is so intense that you have trouble talking.
7 **Severe** – Pain distracts you and limits your ability to sleep.
6 **Moderate** – Pain makes it hard to concentrate.
5 **Moderate** – You can't ignore the pain, but you can still work through some activities.
4 **Moderate** – You can ignore the pain at times.
3 **Mild** – You may notice the pain, but you can tolerate it.
2 **Mild** – You may feel some twinges of pain.
1 **Mild** – You may barely notice the pain.
0 **No Pain**

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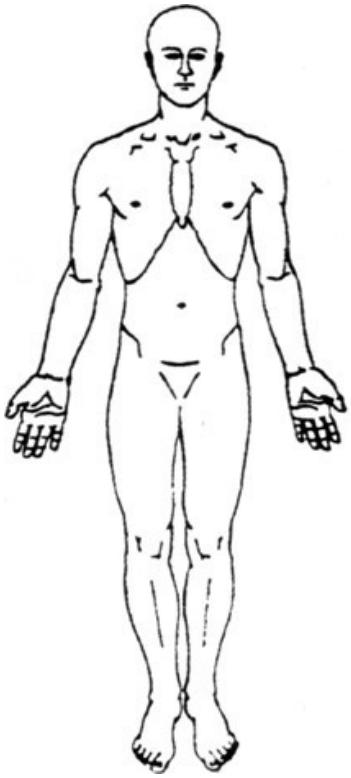

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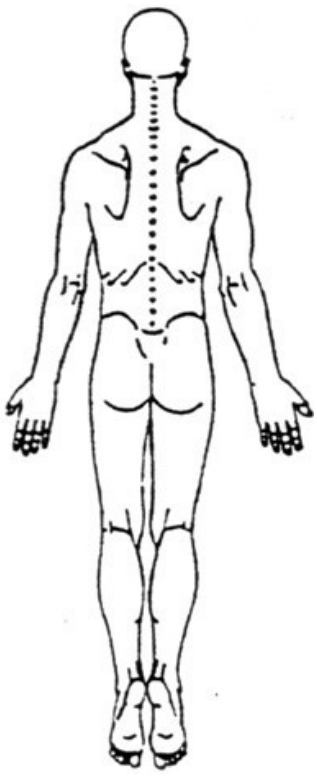

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Follow These Steps

1. CIRCLE areas of pain and write severity, frequency and duration.
   E.g. (6/10, daily, 2-3 hrs.)
2. Mark scars and label.
3. Rate the WORST your pain has been in the last 24 hours:
   ___ /10
4. Rate the LEAST your pain has been in the last 24 hours:
   ___ /10
5. Rate the severity of your pain on AVERAGE for the past WEEK:
   ___ /10

Lifestyle & Main Complaints

Complaints – List your pain and/or health complaints and rate their severity (on a scale of 1-10, with 10 being the worst).

_____

_____

_____

_____

Goals – What would you like to accomplish by seeing Dr. Rehl?_____

_____

Limitations – What limitations do you have, if any, regarding your treatment here and working towards optimal health? (E.g., unwilling to take supplements or do exercises, unwilling to change diet if necessary (i.e. eliminating gluten or dairy), working over 60 hours a week, inability to afford care, etc.)

_____

_____

Energy Level – On a scale of 1-10 (1 is lowest, 10 is highest), what is your energy level during the following times:

AM_____ Afternoon _____Evening _____ Late PM_____After meals _____ Overall_____

Sleep Quality – (Check all that apply) ☐ Restful ☐ Restless ☐ Hard to fall asleep ☐ Wake up often ☐ Nightmares

What time do you usually go to sleep? _____ Hours of sleep per night? _____ Do you wake up during the night? _____

What time(s) do you wake at night? _____ How long does it take before you can fall asleep again? _____

Anything else regarding sleep?_____

Exercise – Do you exercise? _____ How often? _____ How long per session?_____

What type of exercise or physical activity do you do?_____

Smoking and Recreational Drug Use – Do you currently smoke or vape? _____ Circle: TOBACCO MARIJUANA OTHER

How much, how often? _____ How long have you smoked/vaped?_____ Are you exposed to secondhand smoke?____

Please list any recreational drugs/substances you use and how often _____

Daily Habits – How much of these do you consume and how often? (i.e., two 12oz cups per day)

Coffee/Tea _____ Soda _____Alcohol_____Water_____ Fast food _____

What vitamins/minerals are you taking? _____

_____

Allergies – List any known allergies, including food allergies, environmental, seasonal, drug, etc.

_____

_____

Stress – **The Holmes-Rahe Life Stress Inventory**

I. Circle the point value of each life event that you have experienced ***during the last 12 months*** and total the points below.

1.	Death of spouse/partner	100
2.	Divorce	73
3.	Marital Separation from mate	65
4.	Detention in jail or other institution	63
5.	Death of a close family member	63
6.	Major personal injury or illness	53
7.	Marriage	50
8.	Being fired at work	47
9.	Marital reconciliation with mate	45
10.	Retirement from work	45
11.	Major change in the health or behavior of a family member	44
12.	Pregnancy	40
13.	Sexual Difficulties	39
14.	Gaining a new family member (birth, adoption, older adult moving in, etc.)	39
15.	Major business adjustment	39
16.	Major change in financial state (a lot worse or better off than usual)	38
17.	Death of a close friend	37
18.	Changing to a different line of work	36
19.	Major change in number of arguments with spouse (either a lot more or a lot less)	35
20.	Taking on a mortgage (for home, business, etc.)	31
21.	Foreclosure on a mortgage or loan	30
22.	Major change in responsibilities at work (promotion, demotion, etc.)	29
23.	Son or daughter leaving home (marriage, attending college, joining military, etc.)	29
24.	In-law troubles	29
25.	Outstanding personal achievement	28
26.	Spouse/partner beginning or ceasing work outside the home	26
27.	Beginning or ceasing formal schooling	26
28.	Major change in living condition (new home, remodeling, deterioration of neighborhood or home, etc.)	25
29.	Revision of personal habits (dress, associations, quitting smoking, etc.)	24
30.	Troubles with the boss	23
31.	Major changes in working hours or conditions	20
32.	Changes in residence	20
33.	Changing to a new school	20
34.	Major change in usual type and/or amount of recreation	19
35.	Major change in church activity (a lot more or less than usual)	19
36.	Major change in social activities (clubs, movies, visiting, etc.)	18
37.	Taking on a loan (car, tv, stereo, freezer, etc.)	17
38.	Major change in sleeping habits (a lot more or a lot less than usual)	16
39.	Major change in number of family get-togethers (a lot more or a lot less)	15
40.	Major change in eating habits (a lot more or less, different meal hours, or surroundings)	15
41.	Vacation	13
42.	Major holidays	12
43.	Minor violations of the law (traffic tickets, jaywalking, etc.)	11

Total _____

- 150 points or less means a relatively low amount of life change and a low susceptibility to stress-induced health problems.
- 150 to 300 points implies about a 50% chance of a major stress-induced health problem in the next 2 years.
- 300 points or more raises the odds to about 80%, according to the Holmes-Rahe prediction model.

II. Rate your current stress level (in general) on a scale from 1-10 (10 being the most stress): _____

III. Main reasons for stress (may or may not be in above list): _____

_____

_____

Diseases / Conditions – Please describe any diseases or conditions which are under the care of a physician.

Diagnosis _____ Date of onset _____

Current treatment (medication, therapies, etc.) _____

Is your current treatment/medication working successfully? If not, what other treatments have you tried? _____

_____

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Is your current treatment/medication working successfully? If not, what other treatments have you tried? _____

_____

Medications – Check all medications you are taking "NOW" or have taken in the "PAST". Write down the medications and the reason for taking them. If they are past medications, how long did you take them and when? If they are current medications, how long have you been taking them?

	NOW	PAST		NOW	PAST		NOW	PAST		NOW	PAST
Antacids	☐	☐	Birth Control Pills	☐	☐	Hormones (estrogen, progesterone, DHEA, testosterone, thyroid)	☐	☐	Parasite Medication	☐	☐
Antibiotics	☐	☐	Blood Pressure Medication	☐	☐				Steroids (prednisone, anabolic, cortisone)	☐	☐
Antidepressants	☐	☐	Cardiac/Heart Medication	☐	☐						
Antihistamines	☐	☐	Diuretics	☐	☐	Muscle Relaxers	☐	☐	Yeast/Fungal Medications	☐	☐
Anti-inflammatories	☐	☐				Pain Killers	☐	☐			

_____

_____

_____

Trauma & Surgeries – Please check which of the following you have experienced in your life and describe below.

☐ Motor Vehicle Accident(s)	☐ Facial Trauma	☐ Arthroscopy	☐ Laparoscopy	☐ Birth Trauma (giving birth)
☐ Whiplash	☐ Dislocation	☐ Ovary/Uterus Surgery	☐ Appendectomy	☐ Birth Trauma (being born)
☐ Concussion	☐ Sprain/Strain	☐ Breast Surgery	☐ Tonsil/Adenoids	☐ Dental Implants/Surgery
☐ Fractures/Broken Bones	☐ Spinal Fusion	☐ C-Section	☐ Gallbladder Removal	☐ Other Trauma/Surgery/Scar/Burn

Please describe with brief details such as date, outcome, etc._____

_____

_____

Review of Systems – Check "NOW" for all conditions you are currently experiencing, and check "PAST" for any conditions or symptoms experienced in the past that were a ***significant*** or ***recurring problem***, including those with no known cause.

	NOW	PAST
General		
Weight loss	☐	☐
Weight gain	☐	☐
Head		
Headaches	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Blacking out	☐	☐
Eyes		
Change in vision	☐	☐
Cataracts	☐	☐
Light sensitivity	☐	☐
Flashes in vision	☐	☐
Spots in vision	☐	☐
Mouth/Jaw		
Bleeding gums	☐	☐
Cold sores	☐	☐
Dentures	☐	☐
Sore Throat	☐	☐
Jaw pain	☐	☐
Changes in taste	☐	☐
Hoarseness	☐	☐

	NOW	PAST
Nose		
Nosebleeds	☐	☐
Sinus problems	☐	☐
Lungs		
Difficulty breathing	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Persistent cough	☐	☐
Coughing phlegm	☐	☐
Coughing blood	☐	☐
Tuberculosis	☐	☐
Vascular		
Chest pain	☐	☐
Palpitations	☐	☐
Ankle swelling	☐	☐
Cold feet/hands	☐	☐
Leg cramps	☐	☐
Calf pain	☐	☐
Varicose veins	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐

	NOW	PAST
GI System		
Gas	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Ulcers	☐	☐
Vomiting/Nausea	☐	☐
Abdominal Pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Gall bladder disease	☐	☐
Liver disease	☐	☐
GU System		
Difficulty urinating	☐	☐
Pain urinating	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Foul odor of urine	☐	☐
Increased urination	☐	☐
Decreased urination	☐	☐
Urinary infection	☐	☐
Genital infection	☐	☐

	NOW	PAST
Neurologic		
Seizures/Epilepsy	☐	☐
Strokes	☐	☐
Tingling sensation	☐	☐
Numbness	☐	☐
Weakness	☐	☐
Difficulty walking	☐	☐
Poor coordination	☐	☐
Muscle/Bone		
Joint pain	☐	☐
Stiffness	☐	☐
Muscle ache	☐	☐
Arthritis	☐	☐
Bone pain	☐	☐
Skin/Nails/Hair		
Rash	☐	☐
Bruising easily	☐	☐
Changes in moles	☐	☐
Itching	☐	☐
Peeling skin or nails	☐	☐
Brittle nails	☐	☐
Thinning hair	☐	☐

	NOW	PAST
Conditions		
Hypertension	☐	☐
Diabetes	☐	☐
Thyroid condition	☐	☐
Heart condition	☐	☐
Rheumatoid arthritis	☐	☐
Rheumatic fever	☐	☐
Glaucoma	☐	☐
Alcoholism	☐	☐
Cancer/Tumor	☐	☐
Polio	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Gout	☐	☐
Anemia	☐	☐
Osteoporosis	☐	☐
Osteoarthritis	☐	☐
High cholesterol	☐	☐
Migraines	☐	☐
TIAs	☐	☐
Headache unlike any previously experienced	☐	☐

Biological Family History – Check those that apply and indicate their age at onset and outcome (e.g. "heart attack but recovered", "managed with diet and medication", "died", etc.)

	Maternal		*Paternal*							
	Grandma	*Grandpa*	*Grandma*	*Grandpa*	*Mother*	*Father*	*Brother*	*Sister*	*Onset*	*Outcome*
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Arthritis (type)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Thyroid Imbalance	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Other (name)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____

Comments & Additional Information: _____

Rehl Chiropractic
1280 Boulevard Way, Ste. 211, Walnut Creek, CA 94545 925.330.3326 www.michaelrehl.com

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient with Dr. Michael Rehl, D.C., we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may responsible for the payment of your services.)
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to provide other health related information that may be of interest to you.

You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations. Such requests must be made to us in writing. Such requests are not automatic and require the agreement of this office.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine or with a person in your household.

Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. As per allowance by HIPAA the charge will be 25 cents per page. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:
Dr. Rehl 925-330-3326

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W. Washington D.C. 20201. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of January 1, 2010. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Printed Name	Signature	Date

If you are a **minor**, or if you are being **represented by another party**:

Authorized Representative	Signature of Authorized Representative	Date

Description of the authority to act on behalf of the patient: _____

Michael Rehl, DC, PAK, CMT, NC
Rehl Chiropractic

CONSENT FOR CHIROPRACTIC TREATMENT

1. WHAT IS THE NATURE AND PURPOSE OF MY PROPOSED TREATMENT?

You will be receiving chiropractic adjustments, neuromuscular reeducation, deep tissue work, myofascial release, stretching, and exercises as needed.

2. WHAT ABOUT POSSIBLE RISKS?

Chiropractic care is extremely safe. It has been shown repeatedly to be the safest, most effective, and most scientifically validated form of care for the most common cause of back pain—subluxations. There are no known side effects such as those associated with drug therapies. Actually, depending on the case, chiropractic care may save one from more dangerous and invasive procedures later such as surgery.

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 feeling sore or stiff. Soreness can result from the releasing of scar tissue in the joint or muscle that has been reducing your body's function. Soreness usually lasts 1-2 days and then goes away, but the range of motion and function of the joint will have increased. If you ever experience anything painful or have any concerns after care, please let me know! After hours you may reach me, Dr. Michael Rehl at 925-914-0740.

Some complications from chiropractic adjustments are rare. They include strains, sprains and possible rib or other fractures. We use a variety of techniques ranging from light force to moderate force. Our techniques are customized to your level of comfort.

We screen for patients who may be at risk, and techniques for adjusting are designed with safety in mind and patient comfort. Nonetheless, it is impossible to predict all the risks of any kind of care. We promise to put your comfort and safety in the forefront of our minds when making clinical decisions at all times.

3. WHAT ARE SOME ALTERNATIVE TREATMENTS OPTIONS TO CARE HERE?

Some people go to physical therapists or acupuncturists for conditions such as yours. Some people take pain medication or muscle relaxants. *None of these therapies specifically addresses nor corrects the* ***subluxation*** (the medical word for a joint malfunction in the spine or extremity).

4. WHAT CAN I EXPECT IF I OPT NOT TO RECEIVE CARE?

My experience and research has shown that pain medication without therapy is least effective in addressing your underlying problem. For most neck and back pain, chiropractic has proved more effective than physical therapy alone. This is because *physical therapists and medical doctors do not adjust the spine*. Therefore if you choose to not receive chiropractic care, keep in mind that the subluxations in your body will be neglected and the cycle of chronic malfunction, inflammation and adhesions as described above will continue. Ultimately, over years of time, subluxations create bone spurs and spinal decay further reducing mobility. What is commonly called arthritis or osteo-arthritis is now medically referred to as DJD (Degenerative Joint Disease). These degenerative changes can be seen on x-ray. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. Chiropractic care can help prevent this from occurring.

In addition, choosing not to get adjusted means that continued nerve interference may lead to declined health. Our aim is to help you reach your optimal health. If you do not receive care, or stop care prematurely your recovery and optimum functioning may be impaired.

Yours in Health,

Michael Rehl, DC

I have read the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have read the risks involved in 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.

Name of Patient: _____ **Date:** _____

Signature (Parent or Guardian if a minor) : _____

REHL CHIROPRACTIC
ADVANCED HOLISTIC HEALTH CARE

Office Policies

- ✓ We offer email reminders, text reminders, and/or phone reminders for appointments, but ultimately, I accept that it is my responsibility to remember my appointment and be on time.
- ✓ I understand Rehl Chiropractic has a strict 24-hour cancellation and reschedule policy, and a full fee no show policy. *The following fees apply to **all** patients. Those submitting to insurance will have to pay out of pocket.*
- ✓ **Late cancellation or late rescheduling fee** (less than 24 hours' notice)
    - **10-30 minutes appointments -** $35
    - **40-60 minutes, new patient appointments -** $45
    - **Ultimate Combo (double new patient appointments) -** $100
- ✓ **No Show Fee = *full appointment fee*** – *(Examples:* Regular = $97, New patient exam $259, etc.)
    - **What Happens:** After a no show, we will charge your most recently used card on file. As a courtesy, we will try to contact you first to see which card you would like to use.
    - **How to Reduce the Fee:** After the no show fee has been charged, you can reduce the fee by rescheduling and completing your appointment within 7 calendar days of the missed appointment. When you do this, you will pay only the reduced no show fee at your appointment.
    - If you complete the appointment in time:
        - **10-30 mins appointments -** $65-145 no show fee is reduced to $35
        - **40-60 mins, new patient appointments -** $194-291 no show fee is reduced to $45
        - **Ultimate Combo (double new patient appointments) -** $518 no show fee is reduced to $100
    - If you miss the deadline, you will pay for your next session at the normal rate, but you must pay before the session. No discounts are applied to no show appointments or the corresponding rescheduled appointment.
- ✓ Arriving late: If I arrive late, I *may* receive a shortened session as the next patient has a scheduled appointment as well. If I arrive so late that I miss my appointment, I have the option to reschedule for a later time that same day or another day, but I will be subject to the $35 late rescheduling fee.
- ✓ I hereby authorize REHL CHIROPRACTIC to initiate payments that I verbally authorize from my credit card or debit card for payment of services, products, no show fees, and late cancellation fees provided by REHL CHIROPRACTIC. I authorize REHL CHIROPRACTIC to initiate payments from my most recently used credit card if they cannot get ahold of me to secure payment of the appointment fee after a NO SHOW appointment.

I have read the above policies. I understand them and agree to follow them.

Print name: _____

Signature: _____ **Date**: _____