NEW PATIENT HEALTH HISTORY FORM

RiverOne HEALTH & WELLNESS

In Order to provide you with the best care and reach accurate diagnosis, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

PATIENT DATA

Personal Information

Name: _____ (LAST), _____ (FIRST) _____ (MIDDLE INITIAL) DOB: _____ (MM / DD / YYYY) SSN#: _____ Gender: ☐ Male ☐ Female

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP) Occupation: _____

Phone: _____ (MOBILE) _____ (HOME) _____ (WORK) Email: _____

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced Spouse/Partner Name: _____ (IF APPLICABLE) # of Children: _____ (IF APPLICABLE)

Employer

Name: _____

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP) Phone: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

How did you find out about us? Whom may we thank for refferring you to this office: _____

Have you had previous chiropractic care? ☐ Yes ☐ No Have you had previous acupuncture care? ☐ Yes ☐ No

Describe your experience: _____

ACCIDENT INFORMATION

Is condition due to accident? ☐ Yes (Date of accident: _____ (MM / DD / YYYY)) ☐ No

If yes, Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other: _____ (ex) Illness, Gradual onset, Unknown cause)

Where have you made a report of the accdient? ☐ Auto insurance ☐ Employer ☐ Worker's Comp

Attorney (If applicable)

Name: _____ Phone: _____ Claim Number: _____

INSURANCE INFORMATION

Primary Insured Name: _____ Relationship to Patient: _____

Insurance Company: _____ ID#: _____ Group # / Name: _____

Secondary Insurance Information (If applicable)

Secondary Insured Name: _____ Relationship to Patient: _____

Insurance Company: _____ ID#: _____ Group # / Name: _____

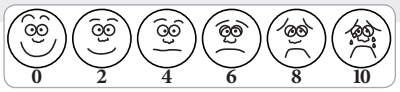
NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____

RiverOne HEALTH & WELLNESS

PATIENT CONDITION

Describe your present major complaints (Rating pain on a scale of 1-10 with 10 being highest)



1. _____ /10
2. _____ /10
3. _____ /10

When does the symptoms get worse? ☐ Morning ☐ Afternoon ☐ Night

How did your symptoms occur? _____ Date Occurred: _____ MM / DD / YYYY

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes ☐ Not Sure

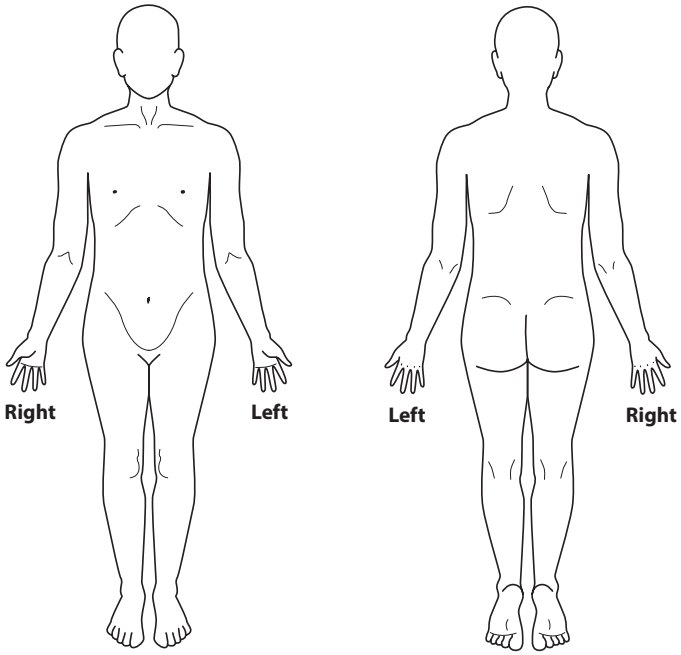
Is this condition interfering with the following? ☐ work ☐ Sleep ☐ Daily Routine ☐ Not Sure ☐ Other: _____

Symptoms have persisted for (number): _____Hours _____Days _____Weeks _____Months _____Years

Check all activities that **AGGRAVATE YOUR CONDITION**:	Check all activities that **RELIEVE YOUR CONDITION**:
☐ Bending ☐ Reaching ☐ Lifting ☐ Sitting ☐ Lying ☐ Standing ☐ Walking ☐ Sneezing ☐ Coughing ☐ Turning ☐ Straining at stool ☐ Other _____	☐ Bending ☐ Reaching ☐ Lifting ☐ Lying ☐ Sitting ☐ Stretching ☐ Standing ☐ Walking ☐ Turning ☐ Self Massage ☐ Cold Pack ☐ Hot Pack ☐ Other _____

How long has it been since you felt really good? _____

PAIN DRAWING Mark your painful spots on the picture. If your pain radiates, draw an arrow from where it starts to where it stops. Use the appropriate symbols to describe the pain.



> > >	Ache	= = =	Numbness	/ / /	Stabing
x x x	Burning	o o o	Pins/Needles	~ ~ ~	Throbbing

Place √ on the SEVERITY OF PAIN SCALE to indicate the level of discomfort that the pain/symptom creates.

▸ Neck / Shoulder / Arm Pain

1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

▸ Mid Back Pain

1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

▸ Low Back and Leg Pain

1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

Other doctors who treated this condition: _____

List any complaints of previous care: _____

NEW PATIENT HEALTH HISTORY FORM

RiverOne HEALTH & WELLNESS

Patient Name: _____

PAST MEDICAL, SOCIAL AND FAMILY HISTORY

Family Physician _____ Phone _____ Last physical examination _____ (MM / DD / YYYY)

Describe any MRI taken: _____ Date: _____

Describe any CT Scan taken: _____ Date: _____

Describe any X-ray taken: _____ Date: _____

List blood test or urinalysis by type and date: _____

_____

Accidents/Injuries

Have you ever been in an auto accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never

Describe: _____

Please list all other injuries/surgeries you have had:

	Falls	Head Injuries	Broken Bones	Dislocations	Surgeries
Description					
Date					

Medications/Supplements

List medicines and supplements you take and the reason you take them:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, what kind? _____

List any other allergy: _____

Habits (note daily amount)

Sleep _____ Tobacco _____ Coffee _____ Tea _____ Alcohol _____

Recreational drug use _____ Other _____

Activities (note type and time spent doing activity)

Exercise _____

Hobbies _____

Nutrition

How many meals do you eat a day? _____ Are you happy with your nutritional state? ☐ Yes ☐ No

Other Health Concerns

Have you been treated/evaluated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, what condition? _____

FAMILY HEALTH HISTORY

List any family history of diseases: _____

_____

_____

ex) Diabetes, Thyroid Disease, Stroke, Kidney Disease, High Blood Pressure, Heart Disease, Cancer (Type), Obesity, Allergies, psychiatric disorder, etc.

FOR OFFICE USE ONLY:

I have reviewed the above past medical, social & family history with the above named patient:

Doctor Signature _____ Date _____

REVIEW OF SYSTEMS

RiverOne HEALTH & WELLNESS

Patient Name: _____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None

Constitutional:
- ☐ **None**
- ☐ Chills
- ☐ Daytime Drowsiness
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes/Vision:
- ☐ **None**
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Itching *(around the eyes)*
- ☐ Phtophobia
- ☐ Tearing
- ☐ Wears Glasses or Contacts

Ears, Nose and Throat:
- ☐ **None**
- ☐ Bleeding Dental Implants
- ☐ Dentures
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Ear Infection(s)
- ☐ Ear Pain
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injury *(history of)*
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Rhinorrhea *(runny nose)*
- ☐ Sinus Infections
- ☐ Snoring
- ☐ Sore Throats
- ☐ Tinnitus (ringing in the ears)
- ☐ TMJ Disorder

Cardiovascular:
- ☐ **None**
- ☐ Angina *(chest pain or discomfort)*
- ☐ Chest Pain
- ☐ Claudication *(leg pain or achiness)*
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Orthopnea *(difficulty breathing while lying)*
- ☐ Palpitations *(irregular or forceful heart beat)*
- ☐ Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- ☐ Shortness of Breath
- ☐ Swelling of Leg*(s)*
- ☐ Ulcers
- ☐ Varicose Veins

Gastrointestinal:
- ☐ **None**
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice *(yellowing of the skin)*
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber *(quality)*
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

Respiration:
- ☐ **None**
- ☐ Asthma
- ☐ Coughing up Blood
- ☐ Shorness of Breath
- ☐ Sputum Production
- ☐ Wheezing

Endocrine:
- ☐ **None**
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Skin:
- ☐ **None**
- ☐ Changes in Nail Texture
- ☐ Changes in Skin Color
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia *(numbness, prickling, or tingling)*
- ☐ Rash
- ☐ History of Skin Disorders
- ☐ Skin Lesions or Ulcers
- ☐ Varicosities

Nervous System:
- ☐ **None**
- ☐ Dizziness
- ☐ Facial Weakness
- ☐ Headaches
- ☐ Limb Weakness
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors
- ☐ Unsteadiness of Gait

Allergy:
- ☐ **None**
- ☐ Anaphylaxis *(history of)*
- ☐ Food Intolerance
- ☐ Itching
- ☐ Nasal Congestion
- ☐ Sneezing

Hematology:
- ☐ **None**
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusion*(s)*
- ☐ Bruises easily
- ☐ Fatigue
- ☐ Lymph Node Swelling

Psychological:
- ☐ **None**
- ☐ Anhedonia *(inability to experience joy or enjoy life)*
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes*(s)*
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Mood Change*(s)*

Female:
- ☐ **None**
- ☐ Birth Control Therapy
- ☐ Breast Lumps / Pain
- ☐ Burning Urination
- ☐ Cramps
- ☐ Frequent Urination
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Male:
- ☐ None
- ☐ Burning Urination
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy or Dribbling
- ☐ Prostate Problems
- ☐ Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: _____ _____
Doctor Signature Date

FINANCIAL AGREEMENT

RiverOne HEALTH & WELLNESS

Patient Name: _____

Release of information
I authorize the release of any information concerning my health and health care services to my insurance companies, or Medicare.

Assignment of Benefits
I authorize and direct that payment be made directly to Ha-il Lee, DC, LAc, RiverOne Health & Wellness LLC for any and all insurance benefits or reimbursement for services rendered by him which amounts otherwise be payable to me under any insurance.

Payment Agreement
I understand that there is no guarantee that my insurance companies will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. All deductibles and co-payments are due at the time of service. I understand that if I do not have insurance, I will be responsible for full payment at the time of service. For your convenience, credit cards, debit cards or HSA accounts can be applied towards payment. If you are unable to pay the entire balance, payment arrangements can be made. Please contact our office.

no show/cancellation policy
We do everything we can to provide the best possible service to all our clients by adhering to a schedule to the best of our abilities. When a client fails to make their appointment time, or cancels at the last minute, that time slot is wasted which could have been used for another patient needing treatment. Given this fact, we require a twenty-four hour cancellation notice. If a client cancels without sufficient notice, we will be forced to charge a $30.00 late cancellation/no show fee.

(We understand that life is complicated. In the event of reasonable unexpected life events, or illness, we will waive this policy. Please phone our office so we can work with you to arrange treatment. This policy is only in place to encourage common courtesy.)

Patient Signature _____ Date _____

Signature _____ Date _____
(Responsible party if under 18)

PATIENT ACKNOWLEDGMENT OF HIPAA NOTICE

RiverOne HEALTH & WELLNESS

Notice to Patient:

We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

Patient Acknowledgment:

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____

Patient Printed Name

_____

Patient Signature or legal representative

_____

If legal representative, state relationship

_____

Date

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details): _____

_____

Name of Patient

_____

Name of Staff Member

_____

Signature of Staff Member

_____

Date

INFORMED CONSENT TO CARE

RiverOne HEALTH & WELLNESS

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

INFORMATION AND INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

RiverOne HEALTH & WELLNESS

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist 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 understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist Name: Dr. Ha-il Lee *DC, LAc, Dipl OM, MSOM*

Patient Signature _____ _____ Date _____
(or Responsible Authority) *(Indicate relationship if signing for patient)*