New Patient Evaluation

Dr Jeff Listiak, D.C.

Please complete the attached forms before your appointment to save time in the office.

Also, please bring a list of any medicines or nutritional supplements you are currently taking.

1132 San Marino Dr Ste 209 San Marcos CA 92078

760-230-2939

Directions: From West San Marcos Blvd, take South Rancho Santa Fe Rd South. Turn Left on Lake San Marcos Dr. Go down the hill to the end and turn Right. Just after C3 Bank turn Right again. My building "1132" is directly in front of you. Proceed up the small hill to the right of the building and park. Look for the sign that says "Executive Suites". Say hello to "Tom" at the front desk. He will let me know you are here and I will come on out to greet you and escort you back to my office, Suite 209.

New Patient Evaluation

Please Print Clearly and Fill In Completely or Mark "N/A" for Not Applicable For Each Item

Print Name _____ Male☐ Female☐ Date of Birth _____
Email _____ Height _____ Estimated Weight _____
Mobile Phone _____
Home Phone _____ Work Phone _____
Street _____ City _____ State ____ Zip _____

Relationship Status *(Circle)*… Married… Lost Spouse… Separated… Divorced… Partnered… Single
Spouse or Partner's name and health status _____
Children's ages and health status _____
Your Occupation _____ Work Duties _____

How did you hear about our clinic or who referred you? _____

Give reason for seeking care: _____
_____

Describe any health problems, including how long you've had them _____
_____
_____

Do these affect your? *(Circle)*… Sleep… Daily Activities… Work… Exercise… Fun… Relationships

What types of doctors have you seen in the past? *(Circle all that apply)*… Cardiologist… Chiropractor… Endocrinologist… General Practitioner… Internal Medicine… Naturopath… Neurologist… Oncologist… Orthopedist… Osteopath… Pain Management… Podiatrist… Psychiatrist… Psychologist… Rheumatologist… Other _____

What other types of health care practitioners have you seen in the past? *(Circle all that apply)*… Acupuncturist… Chinese Medicine Practitioner… Massage Therapist… Nutritionist… Physical Therapist… Weight Loss Practitioner… Other _____

Have you had any recent blood work done? _____
List any X-rays you've had in the last year? _____
List any CT-Scans or MRI's you've ever had and why _____
Other types of tests run? _____
(Females Only): Is there any possibility of you being pregnant? Yes☐ No☐

What are your health goals? _____
_____

_____ _____
Signature Date

Yes☐ No☐ Are you *currently* under the care of any doctor? For what conditions? _____

_____

_____

Physical / Mental / Emotional Stress:

Motor Vehicle Accidents including fender benders, mild / moderate / severe, and how long ago? ___

_____

Sports injuries including type of sport, mild / moderate / severe, and how long ago? _____

_____

Slips & Falls including what you landed on, mild/moderate/severe, and how long ago? _____

_____

Yes☐ No☐ Stitches? Where and why? _____

Yes☐ No☐ Broken bones? Which ones and how long ago? _____

_____

Yes☐ No☐ Hospitalized? For what and how long ago? _____

_____

Any highly repetitive tasks for work or hobbies? _____

How many hours per week do you spend at a desk or on the computer? _____

Anything you do that puts you in a sustained poor posture? _____

Mental stresses such as work or caring for loved ones? _____

Any big decisions coming up? _____

Significant emotional impacts? _____

Sleep & Energy & Habits:

What time do you usually go to bed? _____ What time do you usually get up? _____

How many times do you wake up at night and why? _____

How much energy do you have during the day if 100% was full power? _____

Yes☐ No☐ Do you take any naps? How often and for how long? _____

Yes☐ No☐ Caffeine? How many servings on average per week? _____

Yes☐ No☐ Energy drinks? How many servings on average per week? _____

Yes☐ No☐ Diet Drinks or Artificial Sweeteners? How many servings on average per week? _____

Yes☐ No☐ Sweets? How many servings on average per week? _____

Yes☐ No☐ Use a microwave? How many times on average per week? _____

Yes☐ No☐ Alcohol? How many drinks on average per week? _____

Yes☐ No☐ Smoke? How many packs of cigarettes on average per week? _____

Neuropathy Risk Factors:

Yes☐ No☐ Cancer? What type, where, when? _____

Yes☐ No☐ Have had Chemotherapy?

Yes☐ No☐ Elevated Blood Sugar or Pre-Diabetes or Insulin Resistance or Syndrome X ?

Yes☐ No☐ Diabetes? How long? _____ Current Medication taking? _____

Yes☐ No☐ Cholesterol Meds (Statins)?. How long? _____ Current Medication _____ 2

Yes☐ No☐ Blood Pressure Meds? How long? _____ Current Medication _____
Yes☐ No☐ Circulation Problems? Describe: _____
Yes☐ No☐ Exposure to toxins such as Agent Orange, pesticides, herbicides, industrial chemicals?
Yes☐ No☐ Ever lived in Water Damaged Home. How long did you live there? _____
Yes☐ No☐ Exposure to Black Mold?

Metabolic Section 1:

Yes☐ No☐ Waist is >= 40 inches in Men or >= 35 inches in Women?
Yes☐ No☐ Insulin Resistance or Fasting Blood Sugar is >= 100?
Yes☐ No☐ Excessive Blood Clotting? Current Medication _____
Yes☐ No☐ Low levels of Inflammation?
Yes☐ No☐ Blood Pressure *without medication* is >= 130/85?
Yes☐ No☐ Lack Exercise?
Yes☐ No☐ HDL Cholesterol is <40 in Men or <50 in Women?
Yes☐ No☐ Triglycerides are >= 150

Metabolic Section 2:

Yes☐ No☐ Sexual Dysfunction?
Yes☐ No☐ Bruise easily?
Yes☐ No☐ Poor Wound Healing?
Yes☐ No☐ Eye Health affected?
Yes☐ No☐ Amputations?
Yes☐ No☐ Monitor blood sugar? How often? _____ What does it normally run? _____
Yes☐ No☐ HbA1C Test? What score? _____
Yes☐ No☐ Diabetes? Type? 1 ☐ 2 ☐
Yes☐ No☐ Oral Diabetes Medications?
Yes☐ No☐ On Insulin?

Lifestyle:

Yes☐ No☐ Exercise? How often _____ What type? _____
Yes☐ No☐ Work on posture through Egoscue, Pilates, Yoga, etc?
Yes☐ No☐ Receive regular chiropractic adjustments? How often on average per month? _____
Yes☐ No☐ Satisfied with weight? How many pounds would you like to gain or lose? _____
Yes☐ No☐ Over 50% of food consumed is raw, ie vegetables, fruits, seeds, nuts?
Yes☐ No☐ Take supplements? Which ones? _____
Yes☐ No☐ Periodically do nutritional cleanses?
Yes☐ No☐ Use an electrical device to reduce pain and heal nerve pathways?
Yes☐ No☐ Elevate the legs regularly?
Yes☐ No☐ Wear compression stockings?
Yes☐ No☐ Wear therapeutic shoes such as MBT's, Skechers Shape-Ups, etc?
Yes☐ No☐ Enjoy a strong supportive community locally of family, friends, churches, clubs?
List any foods that you avoid:_____

Please circle any symptoms or conditions below that you currently have or chronically tend to experience:

Symptoms & Conditions	**Symptoms & Conditions**
Feet / Ankles / Legs / Thighs:	Tension Headaches
Sharp Shooting Pain	Migraines
Burning Pain	Eyes
Tingling	Dizziness
Numbness	Ringing in Ears
Weakness	Sense of Smell or Taste
	Memory Loss or Dementia
Hands / Wrists / Forearms / Arms:	Thyroid
Sharp Shooting Pain	Heart
Burning Pain	Lungs
Tingling	Stomach
Numbness	Liver & Gall Bladder
Weakness	Pancreas
	Adrenal Glands
Sleep Disturbance	Intestines
Low Energy	Kidneys
Digestive Trouble	Bladder or Prostate
Circulation Problems	Female Issues
Balance	Male Issues
	Allergies
Pain in the:	Fibromyalgia
Neck	Nervousness
Shoulder	Osteoporosis or Osteopenia
Elbow	Cancer
Mid Back	Diabetes or Pre-Diabetes
Low Back	High Cholesterol (when not on medicine)
Hip	High Blood Pressure (when not on medicine)
Knee	Depression or Bi-Polar (when not on medicine)
Please mark your top three priorities above with an asterisk *	Other:

How are the above symptoms and conditions affecting your life? _____

_____

_____

_____

_____

_____

List any other medications or surgeries not listed above _____

_____

_____

_____

_____

_____

Anything else the doctor needs to know? _____

_____

_____

_____

_____

_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

_____ _____

Signature Date

Consent to evaluate and treat a minor child

I, _____ being the parent or legal guardian of _____ hereby grant permission for my child to receive care.

_____ _____

Signature Date

Privacy Notice

THIS NOTICE DESCRIBES HOW HEALTH 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 of Dr Jeff Listiak, D.C., we may use or disclose personal and health related information about you in the following ways:

- Your protected 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 be responsible for the payment of services provided to you.)
- Your name, address, telephone number, e-mail address and health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, to advise you about health related meetings, workshops and products, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information to treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

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

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- 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 outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive 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 specific form, please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the 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 would like further information or would like to file a complaint about our privacy policies and practices please contact Dr Jeff Listiak at 760-230-2939.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. 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 office utilizes an "open-treatment" environment for ongoing patient care. "Open treatment" involves several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience in our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be treated in an open-treatment environment, other arrangements will be made for you.

This notice is effective as of _____. 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.

_____	_____	_____
Name (Print)	Signature	Date

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

_____	_____	_____
Personal Representative Name (Print)	Personal Rep Signature	Date

_____
Relationship to patient /Authority to act upon their behalf

Informed Consent to Care

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 involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

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 (Print)	Signature	Date
_____	_____	_____
Parent or Guardian Name (Print)	Signature	Date
_____	_____	_____
Doctor Name (Print)	Signature	Date