CHIROPRACTIC HEALTH HISTORY FORM

Please fill out this form as completely and accurately as possible.

PERSONAL DATA

Today's Date_______________Name____ Age __________
Date of Birth _________________
Parent's names (if you are under 18) ____

Home Address________________________________ City __________________ State______ Zip ___________

Home phone (____) ________________________ Business Phone (____) _______________________________

Cell Phone (____) ____________________E-mail address____

____

Business Address______________________________ City___________________State______ Zip __________

SS# (opt'l)____________________________ Emergency contact ______________________________________

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ L/W Spouse/Partner ____

Names and Ages of Children ____

Whom may we thank for referring you to our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel RiverPath Chiropractic can address for you?

____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C.__________________________________

How long under care? ❑ ______days ❑______weeks ❑______ months ❑ years_________

Date of last visit: ______________Why did you stop?____

____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason why: ____

____

FOR WOMAN

Are you pregnant? Y N Date of last menstrual period: ______________________

If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**.

Signature: ______________________________Date:______________________

If **pregnant**, Due Date: __________ Name of OBGYN or Midwife ______________________

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other__________

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the CENTRAL NERVE SYSTEM.
The vertebrae, (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Chiropractors are specialists trained in "early detection" of injury to the
SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and ***how they may relate to your present spinal, nerve and* health *status.***

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please indicate where and how you were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any **accidents or injuries in your life** related to any of the following? (check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state ***type of injury and date:***

____

____

Have you ever **hurt/injured your** spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? ❑ Y ❑ N

If yes, state ***type of injury and date:***

____

____

Have you ever **hurt, broken, fractured or sprained** any bones or joints? ❑ Y ❑ N

If yes, list ***body parts injured and dates:***

____

____

Have you ever been hospitalized? ❑ Y ❑ N

If yes, ***state reason and dates:*** ______________________________

____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated?** ❑ Y ❑ N If yes, did you have a **reaction**? ❑ Y ❑ N

Have you been **exposed to** any of the following on a regular basis, (past or present)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:____

Do you have **allergies** to any foods? ❑ Y ❑ N **If yes, please list:** ____________________

Do you **consume** any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):________________________

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

How do you grade your **physical health**?	❑ Good	❑ Fair	❑ Poor
How do you grade your **emotional/mental health**?	❑ Good	❑ Fair	❑ Poor
How do you rate your overall **"quality of life"**?	❑ Good	❑ Fair	❑ Poor

Do you **exercise** regularly? If yes, how often? ____________________________

Do you take **supplements**? If yes, please list:_____________________________

Do you follow a **special dietary regime**? If yes, what? ________________________

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

❒ Relief of a symptom or problem
❒ Relief and Prevention of a symptom or problem
❒ Healthier spine and nerve system
❒ Optimal health on all levels

RiverPath Chiropractic PreNatal History Form

History, this pregnancy:

Full name: ____

Marital status/Partner's Name: ____

What are your hopes for this pregnancy ____

What are your fears for this pregnancy ____

Number of pregnancies: _________ Number of live births: _________

Complications (Include labor induction, epidural or pain medication, Cesarean Section): __________

____

Did you experience, or receive treatment for, postpartum depression after a previous pregnancy? Yes______ No ______

Previous methods of birth control: __________

When did you stop birth control?__________

Estimated "Due Date": ______________ Date of Last Menstrual Period ____________

How was this pregnancy confirmed?____

Have you received Ultra Sound or Doppler Technology during this pregnancy? ______________

Have you received Amniocentesis or other genetic testing during this pregnancy?______________

____

Are you currently on any medication, or have you been on any medications during this pregnancy?

____

Any supplements?

____

Brand of prenatal vitamin: ____

Brand of DHA supplement: ____

Do you have any allergies, food or other wise ____

Exactly how much water do you drink every day _______________________________________

How can you describe your pregnancy experience so far?_________________________________

____

Have you experienced any of the following joys of pregnancy:

-Back Pain, Cramping, or Round Ligament Syndrome (Pain in lower abdomen into pelvis)?

Yes______ No _______ Please Explain: ____

-Nausea, morning sickness, or vomiting? Yes______ No ______

-Constipation? Yes______ No ______

-Diarrhea? Yes______ No ______

- Swelling of the face, ankles, or extremities? ____________

-High blood pressure? ____________

-High blood sugar/gestational diabetes? ____________

-Iron deficiency anemia? ____________

-Blood Type? ____________

-Bleeding of any sort (Bloody nose, bloody discharge, excessive bleeding with cuts, etc.)?

____

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www.riverpathchiropractic.com

Birth Plans

Where do you plan to give birth? Home__________ Birthing Center__________ Hospital__________
Are you interested in a natural birth coach Yes______ No ______
Name of Birth Practitioner: ____

Medical History

Have you experienced high blood pressure, pre-eclampsia, or eclampsia (toxemia) during this or any other pregnancy? ____

Have you received any Vaccines/Immunizations during this pregnancy, or had any serious illnesses; please explain? ____
____

Have you ever had any of the following illnesses:

-Rubella? Yes______ No ______
-Chicken Pox? Yes______ No ______
-Measles? Yes______ No ______
-Herpes Simplex Type 1/2? Yes______ No _______
-Chlamydia or Gonorrhea Yes______ No _______
-HIV/AIDS? Yes______ No _______
-CMV? Yes______ No _______
-Any Other Known Infectious Disease? Yes______ No _______

Exposure to Toxins

Do you primarily use a cellular phone for communication? Yes______ No _______
Do you sleep next to your phone, laptop or desktop, tablet, etc. Yes______ No _______
Have you been exposed to any of the following services or substances during this pregnancy:

-Hair and/or Nail Salon?Yes______ No _______
-Plastic Water Bottles? Yes______ No _______ -Sodas or Food Artificial Coloring? Yes____ No ____
-Pesticides? Yes______ No _______ -Do You Buy Primarily Organic Produce? Yes_____ No ______
-Alcohol/Pot? Yes______ No _______ -Cigarette Smoke, Tobacco, Nicotine? Yes______ No _______
-Do You Use "Natural" Soaps, detergents, Cleaning Products? Yes______ No _______
-Artificial Sweeteners? Yes______ No _______
-Processed Foods? Yes______ No _______ -Excessive Sugar? Yes______ No _______
-Fish High in Mercury? Yes______ No _______ -Caffeine? Yes______ No _______

Name Signature Date

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Review of Systems

Please mark if you currently or have ever had any of the following:

General:		
Weight loss or gain	▫ Fever or Chills	▫ Trouble Sleeping
▫ Fatigue	▫ Weakness	
Skin:		
▫ Rashes	▫Itching	▫ Color changes
▫ Lumps	▫ Dryness	▫ Hair and Nail changes
Head:		
▫ Headache	▫ Head Injury	
Ears:		
▫ Decreased hearing	▫ Earache	▫ Ringing in Ears
▫ Drainage		
Eyes:		
▫ Vision	▫ Pain	▫ Corrective Lenses
▫ Redness	▫ Blurry or double vision	▫ Cataracts
▫ Specks	▫ Glaucoma	▫ Flashing Lights
▫ Last Eye Exam ________________		
Nose:		
▫ Stuffiness	▫ Itching	▫ Nosebleeds
▫ Discharge	▫ Hay fever	▫ Sinus Pain
Throat:		
▫ Teeth	▫ Gums	▫Bleeding
▫ Dentures	▫ Sore Tongue	▫ Thrush
▫ Dry Mouth	▫ Non-healing sores	▫ Sore throat
▫ Hoarseness	▫ Last dental exam _______________	
Neck:		
▫ Lumps	▫ Pain	▫ Swollen glands
▫ Stiffness		
Breasts:		
▫ Lumps	▫ Discharge	▫ Breast-feeding
▫ Pain	▫ Self-exams	
Respiratory:		
▫ Cough (dry or wet)	▫ Sputum	▫ Wheezing
▫ Couching up blood	▫ Shortness of breath	▫ Painful breathing

Cardiovascular:

- ▫ Chest pain or discomfort
- ▫Difficulty breathing lying down
- ▫ Sudden awakening from asleep with shortness of breath
- ▫ Tightness
- ▫ Swelling
- ▫ Palpitations

Gastrointestinal:

- ▫ Swallowing difficulties
- ▫ Change in bowel habits
- ▫ Yellow skin or eyes
- ▫ Heartburn
- ▫ Rectal bleeding
- ▫ Change in appetite
- ▫ Constipation
- ▫ Nausea
- ▫ Diarrhea

Urinary:

- ▫ Frequency
- ▫ Blood in urine
- ▫ Change in urinary strength
- Urgency
- ▫ Incontinence
- ▫ Burning or pain

Genital:

Male-

- ▫ Pain with sex
- ▫ Sores
- ▫ STD's
- ▫ Hernia
- ▫ Masses or pain
- ▫ Penile discharge
- ▫ Erectile dysfunction

Female-

- ▫ Pain with sex
- ▫ Hot flashes
- ▫ Itching or rash
- ▫ Vaginal dryness
- ▫ Vaginal discharge
- ▫ STD's

Vascular:

- ▫ Calf pain with walking
- ▫ Leg cramping

Musculoskeletal:

- ▫ Muscle or joint pain
- ▫ Back pain
- ▫ Swelling of joints
- ▫ Stiffness
- ▫ Redness of joints
- ▫ Trauma

Neurological:

- ▫ Dizziness
- ▫ Weakness
- ▫ Tremor
- ▫ Fainting
- ▫ Numbness
- ▫ Seizures
- ▫ Tingling

Hematologic:

- ▫ Ease of bruising
- ▫ Ease of bleeding

Endocrine:

- ▫ Heat or cold intolerance
- ▫ Frequent urination
- ▫ Change in appetite
- ▫ Sweating
- ▫ Thirst

Psychiatric:

Respiratory:

- ▫ Nervousness
- ▫ Memory loss
- ▫ Stress
- ▫ Depression

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, Emotional and Chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic Exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

Payment in full is expected on all **FIRST VISIT** services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

First Visit Fees: Comprehensive Exam: X-Rays (full spine):

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Kim McHugh and Dr. Chris McHugh permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature____ Today's Date___________

Signature of Parent (for minor):______________________________ Today's Date___________

Thank you for choosing RiverPath Chiropractic.
We look forward to helping you.

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 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:

Notice of Privacy Practices

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

RiverPath Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

Treatment
We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.

Workers Compensation
We may disclose your health information to as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reaction to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by the Institutions Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to health or safety of a particular person or to the general public.

Marketing
We may contact you for marketing purposes of fundraising purposes.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership
In the event that RiverPath Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that RiverPath Chiropractic is not required to agree to the restriction you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that RiverPath Chiropractic amend your protected health information. Please be advised, however, that RiverPath Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by RiverPath Chiropractic. you have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

RiverPath Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, RiverPath Chiropractic is required by laws to comply with this notice.

RiverPath Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. I f you have questions about any part of this notice or if you want more information about your privacy rights, please contact Drs. Kim and Chris McHugh (DCs), on their office phone at (858) 369-0114. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy Rights or how RiverPath Chiropractic has handled your health information should be directed to Drs. Kim and Chris McHugh, by calling their office at (858) 369-0114. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington DC 20201

This notice is effective as of March 1, 2016.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide RiverPath Chiropractic with my authorization and consent to use and disclose my protected healthcare information for the use purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.

____

Patient’s Name (print)

____ ____________________

Patient/Legal Guardian Signature Date

____ ____________________

Authorized Facility Signature Date

License Notice

As of August 11, 2022, I, Christopher Michael McHugh, have chosen not to renew the chiropractic license with the STATE OF CALIFORNIA. There are pros and cons to this decision.

Pros: I am free to do what is best for you. I am able to learn, study, and grow based on what I know and feel to be the most important.

Cons: I am not able to take health or car insurance. I am unable to write super-bills.

I will continue to accept the following:

- Cash
- Gold/Silver
- Trades
- Credit/Debit/HSA/CareCredit

I will continue to serve you and your family with my fullest love and attention.

______________________________ ________________

Signature Date