HealthTrac Family Wellness

Patient History Information

Please complete this form and then return to the receptionist. **- Please PRINT -**

请完整填写下列表格内容并将此表交还于我们的接待人员
- 请用正楷清晰填写 -

Date 日期: ____________________ Patient #:病例号: ____________________

Last Name
姓: ____________________ First and Middle Name
名: ____________________

Age 年龄: ________ Date of Birth 出生年月: ____________ ❑ Male 男 ❑ Female 女

Is your visit to our clinic today for care resulting from an auto accident or workers compensation injury?
您今天来此门诊的原因是由于遭受车祸伤害或是由于工作受伤吗? ❑ Yes 是 ❑No 否

Home Address 家庭住址: ____

City 城市: ____________________ State 省（市）: ____ Zip Code 邮编: ____________

Telephone
电话: Home
座机: ____________________ Work
工作电话: ____________ Mobile
移动电话: ____________

Social Security #
社会保险号码: ____________________ Email
电子邮件: ____________________

Occupation 职业: ____________________ Employer 公司名称: ____________________

Work Address 工作地址: ____

City 城市: ____________________ State 省（市）: ________ Zip code 邮编: ____________

Marital Status 婚姻状况: ❑ Single 单身 ❑ Married 已婚 ❑ Divorced 离异 ❑ Widowed 丧偶

Spouse's Name
配偶姓名: ____________________ Number of Children
子女: ____________ Ages
年龄: ____________

Phone Number 电话: ____________________

Emergency Contact Person 紧急联系人: ____________________ Phone Number 电话: ____________

Have you received chiropractic care in the past? ❑ Yes 是 ❑ No 否 When?
你之前接受过脊骨神经矫正治疗吗? 于何时? ____________

If yes, please give name of the Chiropractor:
如果是，请提供脊骨神经矫正医师姓名: ____

Please describe the reason for previous care:
请描述之前接受矫正的原因: ____

Name of your Medical Doctor
西医的名字: ____

List the name of your health insurance company:
健康保险公司的名字: ____

Policy number is:
保险单号码是: ____

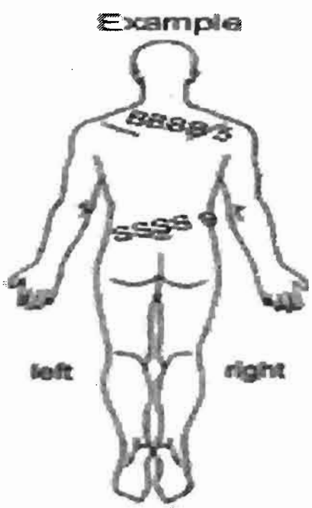
Patient Name:______________________________ Date:_____________ File:____________________

Reason(s) for seeking chiropractic care starting with the most severe:
列举需要脊骨神经矫正治疗的原因，请从最严重的问题开始：

Chief Complaint 健康问题及相关	Approximate Date Started 大概开始日期
1. ______________________________	______________
2. ______________________________	______________
3. ______________________________	______________

Areas of injury or discomfort:
损伤区域/不适区域:

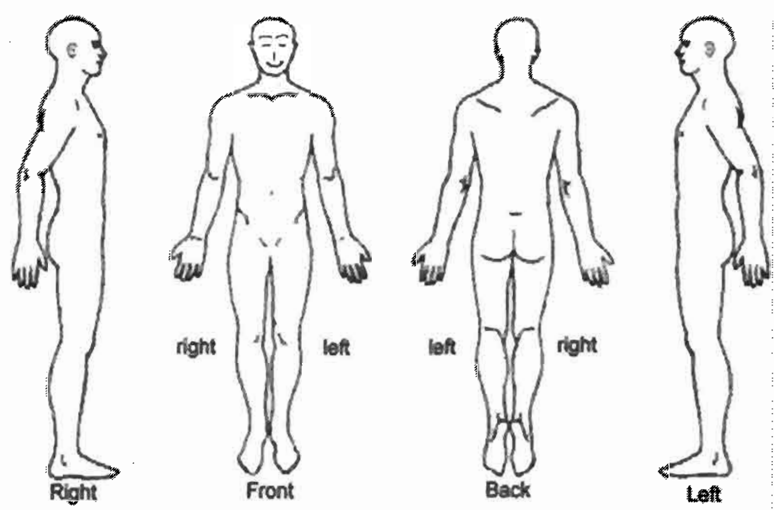
On the following chart please mark area(s) of injury or discomfort (see example). Mark all areas with the appropriate symbols and indicate the degree of pain on a scale from 1 (discomfort) to 10 (extreme pain).
请在下列图表中标明您的损伤区域或者不适区域（参见示例） 并在所有表示区域中标明相应痛感与等级 1（略微不适）到 10（极度疼痛）



参见示例

NNNN Numbness 麻木
PPPP Pins & Needles 针刺感疼痛
BBBB Burning 灼热感
AAAA Aching 酸、胀痛
SSSS Stabbing 刺痛

Circle any area of pain not represented by a symbol.
请在右图圈出疼痛区域，并标痛感和程度（1-10）



右侧 右 正面 左 左 背面 右 左侧

Please indicate any medications you are currently taking:
请提供近期任何相关用药史：

- ❑ Blood pressure 高血压
- ❑ Muscle relaxants 肌肉松弛剂
- ❑ Stimulants 神经药物
- ❑ Blood thinners 血液稀释剂
- ❑ Steroids 类固醇
- ❑ Birth control pills 避孕药
- ❑ Stimulants 兴奋剂
- ❑ Pain killers (including Aspirin) 止痛剂（包括阿司匹林）
- ❑ Insulin 胰岛素
- ❑ Antibiotics 抗生素
- ❑ Sleeping Pills 安眠药

❑ Others 其它：______________________________

Name of nutritional supplements and/or dietary aids:
营养/膳食补充剂名称: ______________________________

Patient Name:________________________ Date:__________ File:______________

Review of Systems, Please check any condition you have had in the past or have now:
系统评价 若你过去或者现在有以下状况，请在方框内打勾：

Now 现在	Past 过去		Now 现在	Past 过去		Now 现在	Past 过去	
❑	❑	Back Pain 背部疼痛	❑	❑	Chest Pain 胸部疼痛	❑	❑	Difficulty Urinating 泌尿困难
❑	❑	Neck Pain 颈部疼痛	❑	❑	Poor Circulation 循环不畅	❑	❑	High BP 高血压
❑	❑	Shoulder/Arm Pain 肩/手臂疼痛	❑	❑	Skin Problems 皮肤问题	❑	❑	Arrhymia 心律不齐
❑	❑	Hip/Leg Pain 髋部/腿部疼痛	❑	❑	Colon Trouble 肠道	❑	❑	Frequent Infections 经常感染
❑	❑	Sciatica 坐骨神经痛	❑	❑	Stomach Trouble 胃	❑	❑	Difficulty Breathing 呼吸困难
❑	❑	Arthritis 关节炎	❑	❑	Kidney Problems 肾脏	❑	❑	Liver Trouble 肝脏
❑	❑	Asthma 哮喘	❑	❑	Easy Bruising 易青肿	❑	❑	Pregnancy 女性：怀孕
❑	❑	Prostate Problems 男性：前列腺				❑	❑	Menstrual Problems 月经问题
❑	❑	None of the above 无以上症状	❑	❑	None of the above 无以上症状	❑	❑	None of the Above 无以上症状

Have you ever: 你是否曾经 ***Comments: 评价:***

Had any accidents, falls, traumas, or injuries:
遭受过意外事故、跌伤、损伤或伤害: ❑Yes 是 ❑ No 否 ______________________
Been hospitalized 入院治疗: ❑ Yes 是 ❑ No 否 ______________________
Had a broken bone 骨折历史: ❑ Yes 是 ❑ No 否 ______________________
Had surgery 外科手术: ❑ Yes 是 ❑ No 否 ______________________
Been treated for an emotional disorder
因为情绪障碍接受治疗: ❑ Yes 是 ❑ No 否 ______________________
Been bedridden for more than a week
卧床一周以上: ❑ Yes 是 ❑ No 否 ______________________

Health/Risk Factors: 健康/危险因素: ***Comments: 评价:***

Do you smoke? 您吸烟吗？ ❑ Yes 是 ❑ No 否 If yes ❑ Occasional ❑ Light ❑ Medium ❑ Heavy
Do you drink alcohol? 您喝酒吗？ ❑ Yes 是 ❑ No 否 If yes ❑ Once/Week ❑ 2-5 Times/Week ❑ Daily
Do you have a healthy diet?
您的饮食合理吗？ ❑ Yes 是 ❑ No 否 ______________________
Do you exercise regularly?
您经常锻炼吗？ ❑ Yes 是 ❑ No 否 If yes ❑ Occasional ❑ 3-5 Times/Week ❑ Daily
Do you sleep well? 你的睡眠好吗？ ❑ Yes 是 ❑ No 否 ______________________
Is your job stressful?
您的工作压力大吗？ ❑ Yes 是 ❑ No 否 ______________________
Do you drink caffeine? 你喝咖啡或茶吗？ ❑ Yes 是 ❑ No 否 If yes ❑ Occasional ❑ Daily
What is your dominate hand?
你是用哪个手写字？ ❑ Right 右手 ❑ Left 左手 ❑ Both 两个手都可以
Can you think of any other habit or activity that has a positive or negative effect on your health?
您还能想到一些对您的健康有益或者有害的生活习惯吗？ ❑ Yes 是 ❑ No 否 ______________________

Patient Name:_________________________ Date:___________ File:_______________

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_________________________ _________________________ _______________

Print Name / 姓名（写正楷） Signature / 签名 Date / 日期

Consent to evaluate and adjust a minor child:

I, _________________________ being the parent or legal guardian of _________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

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

HealthTrac Family Wellness, Inc

On Track to Great Health

Consent For Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by **HealthTrac Family Wellness** (also HTFW) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **HTFW**. I understand that diagnosis or treatment of me by **Dr. George Hui, D.C.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. **HealthTrac Family Wellness** is not required to agree to the restrictions that I many request. However, if **HTFW** agrees to a restriction that I request, the restriction is binding on **HTFW** and **Dr. George Hui, D.C.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. George Hui, D.C.** or **HTFW** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **HTFW's** Notice of Privacy Practices prior to signing this document. The **HTFW's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of **HTFW**. This Notice of Privacy Practice also describes my rights and **HTFW's** duties with respect to my protected health information.

HealthTrac Family Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

________________________________	________________________________
Signature of Patient or PR/ Date 病人签名　　　日期	Please Print Name of Patient or PR 姓名（用正楷写名字）

____

Description of Personal Representative's Authority

HealthTrac Family Wellness

NO SHOW / CANCELLATION POLICY

Our goal is to meet the needs of our patients and we will make every effort to efficiently schedule your appointments. **In return, it is your responsibility to make every effort to keep your scheduled appointments and arrive promptly at the time instructed.** However, we realize that unanticipated events may prevent you from keeping your appointment. In fairness and consideration to our other patients, we hereby request that you notify our office immediately when you realize you will not be able to keep your appointment.

If you need to cancel or reschedule your appointment, you must do so **at least 24 hours before your scheduled office appointment** to avoid paying a fee. In an effort to see patients promptly at the schedule time, this office does not double-book appointments; therefore, the 24 hour notification is necessary so that we may schedule other patients needing immediate appointments.

Missed office appointment fee is $50.00

**Fees are not covered by insurance and must be paid before you can reschedule your appointment.

我們的目標是滿足患者的需求，我們將盡一切努力有效地安排您的预約。同时，您也有責任盡一切努力保持預定的预約，並在约定的時間及時到達。但是，我們意識到，突发事件可能會妨碍您准时到达您的预约。出於對我們其他患者的公平和考慮，我們特此请求您，當您意識到無法准时到达預約時，應立即通知我們診所。

如果您需要取消或重新安排预約，則必須在预約时间的至少 24 小時前取消或重新安排预約，以免支付費用。為了及時在安排的時間看病人，本诊所不重複預約。因此，有必要提前 24 小時通知我们，以便我們安排其他有需要立即預約的患者。错过预约需支付費用如下：$50. 00。

**費用不在保險包含範圍之內，必須在重新安排预約之前支付。

*Nuestro objetivo es satisfacer las necesidades de nuestros pacientes y haremos todo lo posible para programar sus citas de manera eficiente. **A cambio, es su responsabilidad hacer todo lo posible para cumplir con sus citas programada y llegar puntualmente a la hora indicada.** Sin embargo, nos damos cuenta de que los eventos imprevistos pueden impedir que cumpla con su cita. Para ser justos y considerados con nuestros otros pacientes, le solicitamos que notifique a nuestra oficina de inmediato cuando se dé cuenta de que no podrá asistir a su cita.*

*Si necesita cancelar o reprogramar su cita, debe hacerlo **al menos 24 horas antes de su cita programada para evitar pagar una tarifa.** En un esfuerzo por ver a los pacientes puntualmente a la hora programada, este consultorio no reserva citas dobles; por lo tanto, la notificación de 24 horas es necesaria para que podamos programar otros pacientes que necesiten citas inmediatas.*
La cuota para una cita perdida es: $ 50.00

** Las tarifas no están cubiertas por el seguro y deben pagarse antes de que pueda reprogramar su cita.

______________________________ ________________________

Patient Signature / 病人签名/ *Firma del paciente* Date / 日期/ *Fecha*

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Patient Signature / 病人签名/ *Firma del paciente* Date / 日期/ *Fecha*