Date_____

Name_____ **Address**_____

City_____ **State**_____ **Zip Code**_____ **Age**_____ **Birth Date**_____

SS #_____**E-Mail** _____ **Referred by** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Marital: M S W D How many Children? _____

Occupation (if dependent list parent's occupation) _____

Employer_____ Address _____Phone_____

Name of Spouse _____ Address _____Phone_____

Emergency Contact _____Phone _____ Other Phone _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT! * Cash * Check * Visa/MC

Person responsible for payment

Name_____ Phone _____ Other _____

Address_____ City _____ Zip _____

Other Doctors seen for this Condition_____

Primary Complaint(s): _____

_____

_____

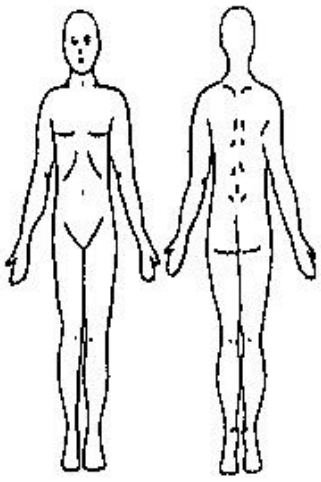
Have you been treated for any health condition by a physician in the last year? *** YES * NO**

Overall Frequency of Complaint: o Constant-100% o Frequent-75% o Intermittent-50% o Occasional-25%
Overall Intensity of Complaint: o Minimal o Slight o Moderate o Severe

Hobbies:

_____

_____



Confidential Health History

Please outline on the diagram the area of your discomfort.
Please describe your present complaints

_____

_____

_____

_____

_____

_____

Is this a work related injury? o YES o NO

When did your present complaints occur? _____

Who has treated you for this condition (if anyone)? _____

Is this condition interfering with your o Work o Sleep *Recreation o Dates missed: _____

Have you taken anything to help you with this condition o YES o NO Please list: _____

Have you applied ice or heat to the areas of pain o YES o NO

Have you had this condition or similar conditions in the past? oYES o NO If so, when? _____

What treatment did you receive? _____

Name & location of previous chiropractor: _____

Approximate date of last chiropractic treatment: _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto accidents: _____ Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken bones: _____ Knocked unconscious: _____

Surgeries: _____ Health problems of parents: _____

Please describe your condition when it is at its worst: _____

_____

On a scale of **1- 10** please rate the intensity of your **pain now _____a**nd when this **pain first occurred_____**

Please circle any of the following that apply to your current/past medical history:

- o Allergy
- o Asthma
- o Shoulder pain
- o Heartburn
- o Hay fever
- o Hiatal hernia
- o Migraines
- o Sore throats
- o Loss of weight
- o Shortness of breath
- o Hardening of arteries
- o Liver trouble
- o Hyperactivity
- o Numbness in legs or feet
- o Stroke
- o Swollen ankles
- o Stomach ulcers
- o Foot trouble
- o Frequent urination
- o Kidney stone
- o Kidney infection
- o Bladder infection
- o Painful urination
- o Poor urine control
- o Blood in urine
- o Prostate trouble
- o Swollen joints
- o Belching or gas
- o Fainting
- o Colon trouble
- o Headaches
- o Nosebleeds
- o Tuberculosis
- o Difficulty breathing
- o Jaundice
- o Polio
- o Bursitis
- o Poor circulation
- o Sprained ankle
- o Vomiting of blood
- o Bed-wetting
- o Low backache
- o Painful tailbone
- o Sciatica
- o Spinal curvature
- o Stiff or painful neck
- o Leg pain
- o Pain between shoulders
- o Arm Pain
- o Knee Pain
- o Thyroid trouble
- o Diabetes
- o Enlarged Glands
- o Gout
- o Nasal congestion
- o Itching
- o Chronic cough
- o Heart disease
- o Hemorrhoids
- o Cancer
- o Arthritis
- o Chest pain
- o Vomiting
- o Broken bones
- o Weakness in legs
- o Rheumatic fever
- o Sinus infection
- o Convulsions
- o Stomach aches
- o Dentures
- o Bruise easily
- o Diarrhea
- o Varicose veins
- o Gall bladder trouble
- o Depression
- o Emphysema
- o Low blood pressure
- o Poor appetite
- o Surgery
- o Weakness in arms
- o Slow heart beat
- o Bad posture
- o Anemia
- o Poor hearing
- o Burning sensations
- o Fatigue
- o Eczema/Hives
- o Constipation
- o Loss of sleep
- o Excessive hunger
- o Nervousness
- o Spitting up blood
- o High blood pressure
- o Nausea
- o Tumor
- o Numbness in arms/hands
- o Rapid heart beat
- o Difficulty swallowing
- o Heart attack
- o Ringing in ears
- o Angina

For Women Only:

- o Premenstrual tension
- o Menopausal symptoms
- o Excessive flow
- o Tubal ligation
- o Vaginal discharge
- o Unable to get pregnant
- o Menstrual cramps
- o Hysterectomy
- o Lumps in breast
- o Irregular cycle

Is there a possibility that you may be pregnant? a YES a NO

Date of last menstrual period_____

_____

California Code of Regulations require that you are informed of material risk of chiropractic care. This risk is defined as a" procedure that inherently involves known risk of serious bodily harm." By signing you acknowledge that you have been informed both verbally and in writing of this material risk.

Patient's Signature _____ Date_____

Guardian Signature _____ Date_____

Acknowledgment of Financial Responsibility

Your insurance policy is a contract between you and your carrier. These days, many policies reimburse for at least *some* chiropractic care. But coverage varies from policy to policy and constantly changes.

Our goal is to help you get well but more important, to help you *stay* well. This can be at odds with the profit motives of insurance companies.

So, to protect our freedom to recommend what's truly best for you, we don't attempt to serve two masters. It's your health and you're the boss. So, we do not take insurance assignment. Instead, payment for our services will be your responsibility. This benefits you in several ways:

May increase your coverage. When we file your claim, your company may suspect that we've "sold" you unnecessary care. Their suspicion can reduce your coverage. You're more likely to get the full benefits of your policy if you file your own claims..

You'll receive better care. Doctors under contract with third parties are often prevented from making optimal recommendations. Fearing they will be cut from the "approved" list, they can be pressured into minimizing your problem.

You'll see faster results. When you pay the bill, you'll be motivated to make lifestyle changes and participate more actively in your care. As you would expect, this produces faster, more consistent results.

You'll get more attention. Human nature being what it is, by paying for your own care, you'll be seen as a more responsible, desirable patient.

We will explain the purpose of every procedure. We will supply you with the documents you'll need for filing a claim with your carrier. Please note that some of our services may not be reimbursable under your policy.

I accept financial responsibility for my care and instruct this office to deliver the care that, in their judgment, can best help me in the restoration of my health.

_____

Patient name

_____

Signature Date