Chiropractic Works! Health and Wellness Center

Where Better Health Happens

Thank you for choosing us to help you with your health and wellness needs. This packet is designed to save you time in our office waiting room, filling out papers on a clipboard.

Please make yourself a cup of tea or something nice, sit down and take twenty minutes to thoroughly enter your current health status and let us know your health goals. There are a few items that are repeated for the sake of completing the health survey.

Because you will bring in a completed form, we will get to you more quickly and the doctor will be better prepared with a more complete health history.

Thank you again for being thorough. Enjoy the journey.

Enclosed: 12 pages of Patient Intake forms

195 E. Hillcrest Drive, Suite 115, Thousand Oaks, CA 91360 (805) 777-7184

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PERSONAL HISTORY

DATE: _____ Email Address: _____

NAME:_____BIRTHDATE:_____

AGE: _____ GENDER: M F HEIGHT:_____WEIGHT: _____

ADDRESS:_____

PHONE (____) _____ TYPE OF WORK: _____

CHECK ONE: __MARRIED __SINGLE __WIDOWED __DIVORCED __SEPARATED

NUMBER OF CHILDREN: _____ AGES: _____

WHO IS RESPONSIBLE FOR YOUR BILL? YOU AND: SPOUSE AUTO INSURANCE

PERSONAL HEALTH INSURANCE OTHER: _____SSN:_____

Insured's Name:_____Birthdate:_____ID:_____

Insured's Employer:_____Employer Phone:_____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT: _____

_____

MAJOR COMPLAINT: _____

WHEN DID THIS CONDITION BEGIN: _____

WHERE WERE YOU WHEN THIS HAPPENED: _____

IF DISABLED FROM WORK, GIVE DATES: _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

MEDICATION YOU NOW TAKE: NERVE PILLS PAIN KILLERS MUSCLE RELAXERS

BLOOD PRESSURE INSULIN ASPIRIN TYLENOL ALLERGY OTHER_____

PAST HEALTH HISTORY *PLEASE CIRCLE OR DESCRIBE:*

MAJOR SURGERY/OPERATIONS: APPENDIX TONSILS GALL BLADDER HERNIA

HEART BACK NECK LEG OTHER _____

MAJOR ACCIDENTS/FALLS: _____

_____

OTHER HOSPITALIZATION: _____

PREVIOUS CHIROPRACTIC: LAST VISIT DATE _____DR'S NAME _____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION THIS LAST YEAR? YES NO

IF YES, PLEASE EXPLAIN_____

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WHY CHIROPRACTIC? People go to Chiropractors for a variety of reasons. Some go for relief of painful symptoms (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (CORRECTIVE CARE). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (COMPREHENSIVE CARE). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Comprehensive Care

☐ Please have the doctor select the best type of care for my condition.

_____ _____

Date Patient's Signature

If this is an accident-related injury, please ask for the Accident form.

THE PURPOSE OF OUR CHIROPRACTIC HEALTH AND NUTRITION CENTER IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM LEVEL OF HEALTH AND TO EDUCATE EACH PERSON SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC, THEN IN TURN, EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition, as she deems appropriate through the use of manipulation throughout my body. It is understood and agreed the amount paid the doctor for x-rays is for examination, and the x-ray negative will remain property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature_____Date_____

Guardian/Spouse Signature Authorizing Care_____

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PATIENT-DOCTOR AGREEMENTS

The purpose of these agreements is to allow us to more completely serve you and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

SIGN IN

When you arrive, sign in at the front desk and pull your treatment card out of the box. You will be called and assigned a treatment room in the order you signed in for your Doctor (given you have arrived on time for your appointment). When you go to the assigned treatment room, place the folder in the door tray and lie face down. Rest and relax, the Doctor will be in as soon as possible.

WELLNESS ORIENTATION WORKSHOP *Stress and Wellness Seminars*

It is mandatory that all patients attend our Wellness Orientation Workshop. This group consultation explains how the body functions, how Chiropractic works and how results are produced. Family and friends are welcome. There is no charge for the consultation. If you are unable to attend, extra time will be set aside on one of your visits and there will be an additional personal charge for a private workshop with the Doctor at a rate of $4 per minute (normally we allow 30 minutes to cover all of the points). Please attend the next group workshop.

MISSING OR CHANGING APPOINTMENTS

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time is required for us to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day. If the same day is not possible, be sure to make up the missed appointment within 7 days. If you miss your appointment or give less than a 24-hour notice and do not reschedule, there is a personal service fee of $65.00.

PROGRESS EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, progress evaluations and check ups may take place. The fee for these services should be paid according to your payment agreement. Please refer to the Initial Visit Financial Policy you received

DIETS AND FOOD SUPPLEMENTS

Diets should be followed and vitamin supplements taken as recommended by your Doctor or the Nutrition Counselor. Any problem you may have with these recommendations should be communicated. We do not prescribe, but will make recommendations to help speed your recovery. You are expected to pay for food supplements at the time of purchase. If you experience problems with any supplements, handle it with the doctor.

NEW SYMPTOMS - IMPORTANT!

Notify us right away if you are experiencing pain or discomfort in areas not addressed in your initial consultation or if you have a new injury. NOTE: If you are scheduled during our busiest patient hours, the Doctor may not have the time to properly address your new complaint. If this is the case you will be rescheduled later that day or the next day so the proper work up can be done.

UPSETS

We are here to serve you. Please speak with your Doctor about any upsetting matter, i.e., long waits, staff insensitivity, confusion about treatment, etc. We see your comments as helping us to help you and others.

TERMINATION OF CARE

Do not dismiss yourself from care. We are ethically and legally responsible for your health care once we accept you as a patient. If you wish to discontinue care, notify the office and you will be scheduled for a no charge update consultation and examination to update your records.

If you stop care without this update consultation and exam you will be required to pay all outstanding fees in full immediately, regardless of previous financial arrangements. However, if you comply with this agreement we will honor whatever financial agreements are in place.

_____ _____

Patient's Signature date

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WOMEN'S HEALTH SCREEN

Name_____Age_____Today's Date._____

Current health problems/concerns: _____

_____

Current medications, prescription (i.e. hormones) or over-the-counter _____

General Health (check any that apply):

Chronic fatigue___Irritability___Shortness of breath___Headaches___Bone pain___Memory fails ____

Have you experienced unintentional weight loss or gain of 10 pounds or more in the last three months __

Gynecological History:

Date of last gynecological exam (PAP, mammogram) Results, _____

Date of last menstrual cycle Length of cycle _____ Interval of time between cycles _____

Any recent changes in normal menstrual flow Age of first period _____

Form of birth control Number of children _____Number of pregnancies_____

C-section ___ Surgical menopause, date_____ Describe Surgery _____

Endometriosis__ Infertility__ Fibrocystic Breasts__ Fibroids/Ovarian Cysts__Reproductive cancer__

Pelvic Inflammatory Disease__Vaginal Infections __ Vaginal Yeast__ Genital Herpes__ STD__

Family Medical History (check any that apply):

Breast or other cancers __ Cardiovascular disease __ Osteoporosis __ Obesity __ Alcoholism__

Mental Illness/Depression __ Alzheimer's __ Diabetes __ Arthritis _____Stroke _____

Lifestyle & Diet:

Rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) ____ _____

Identify the major causes _____

Do you eat (check any that apply):

Sweets, sodas, ice cream __ Fried foods __ Whole grains, legumes, cereals __ Fruits/vegetables ____

List your 4 favorite foods _____

Do you (check any that apply):

Diet frequently __ Skip meals __ How many meals do you eat per day __ Dine out regularly __

Use tobacco/smoke cigarettes __ How many cigarettes per day _____ Exposed to passive smoke __

Drink coffee __ # cups per day __ Strong __ Mild __ Decaffeinated __ Eat Chocolate __

Drink alcoholic beverages ____ How many ounces per day/per week Preference _____

Exercise daily __ How many times per week/activity: _____

Do you restrict your intake of or avoid completely (check any that apply):

Dietary fat __ Dairy products __ Animal protein __ Salt __ Fiber __ All animal foods __

Check the symptoms you experience regularly <u>one to two weeks before</u> your period:

Part 1

1. __ Anxiety
2. __ Irritability
3. __Nervous tension
4. __ Aggressive or hostile toward family/friends
5. __ Engage in self destructive behavior
6. __ Weight gain
7. __ Water retention
8. __ Abdominal bloating
9. __ Tender, swollen and/or painful breasts
10. __ Breast lumps increase in size and tenderness
11. __ Discharge from nipples
12. __ Craving for sweets
13. __ Increased appetite
14. __ Heart palpitations
15. __ Fatigue
16. __ Headaches
17. __ Shaky or clumsy
18. __ Depressed
19. __Withdrawn
20. __ Confused
21. __ Forgetful
22. __ Insomnia/difficulty sleeping

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Check the symptoms and/or behaviors that occur <u>during your period</u> with a* frequency *or intensity that affects your daily activities:

Part 2

1._ Cramping in lower abdomen or pelvic area
2.__ Sharp intermittent pain
3.___ Dull aching pain
4.__ Upset stomach
5._ Diarrhea
6._ Nausea or vomiting
7._ Low back aches
8._ Headaches
9,__ Difficulty concentrating
10. ___ Accident prone
11._ Unusual fatigue (take naps)
12._ Decreased productivity
13._ Weight gain
14._ Painful and/or swollen breasts
15,__ Irritability
16._ Mood swings
17,__ Depression
18,__ Painful intercourse

Check off any of the following statements <u>that describe</u> your menstrual cycle, energy level or reproductive function:

Part 3

1.__ Heavy prolonged menstrual bleeding/clotting
2.__ Menstrual bleeding that lasts longer than 5 days
3.__ Absence of periods for 3 months or more
4.__ Vaginal itching, burning, dryness
5.__ Menstruation that occurs too frequently (every 21-24 days)
6,__ Irregular periods (once every three to six months)
7.__Frequently skip periods
8.__ Menstrual cycle every 36 days or longer
9__ Unusually light or heavy periods
10.___ Unusually light menstrual flow - "spotting"
11. __ Menses last three days and are light
12.__ Bleeding or spotting between period s
13.__ Bleeding between periods is light - "staining"
14.__ Bleeding between periods is heavy and/or clots
15.__ Abnormal vaginal discharge
16.__ Frequent urination

Check any of the following symptoms if they occur <u>throughout the month</u> with an intensity or frequency that affects your ability to perform your daily activities or feel good about yourself

Part 4

1.__ Decline of vital energy and sense of well-being
2.__Hot flashes
3.__ Night sweats
4.__ Spontaneous sweating
5. __Chills
.6.__ Depressed
7. __Irritable
8.__ Anxiety
9,__ Anger
10,_ Mood swings
11. Headaches
12._ Forgetful
13 ._. Difficulty concentrating
14._ Difficulty sleeping
15.__ Urinary problems
16._ Vaginal problems
17,_ Dry skin
18. __ Bleeding between periods
19._ Irregular periods
20,_ Stopped menstruating
21._ Joint and muscle pain
22,_ Change in sexual desire
23._ Difficulty with orgasm
24,_ Painful intercourse
25,__ Loss of muscle tone
26,_ Vaginal bleeding any time
27._ Vaginal bleeding after sex
28._ Vaginal discharge

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MEN'S HEALTH SCREEN

NAME: _____ DATE: _____ _

What is your age?	0 Younger than 60	0 Older than 60
Do you have diabetes?	0 Yes	ONo
Do you have asthma?	0 Yes	ONo
Do you have prostate problems?	0 Yes	ONo
Do you take medications for any of theses problems?.....	O Yes	ONo
How much do you usually sleep?	0 Less than 5 hours	o More than 5 hours
Do you smoke cigarettes?	0 Currently	oIn past 0 Never
Have you recently been bothered by headaches?	OYes	ONo

Find the column for your height and weight. Mark your weight. Check only one diamond.

5' or under	5'4" to 5'6"	5'10" to 6'	6'4" to 6'6"
0 less than 135 lbs	0 less than 160 lbs	0 less than 195 lbs	0 less than 230 lbs
0135-150Ibs	0160-180 lbs	0195-2151bs	0230-2551bs
0 over 150 lbs	0 over 180 lbs	0 over 215 lbs	0 over 255 lbs

5'1" to 5'3"	5'7" to 5'9"	6'1" - 6'3"	6'7" or taller
o less than 150 lbs	o less than 180 lbs	0 less than 210 lbs	0 less than 245 lbs
o 150-1651bs	o 180-195 lbs	0210-235 lbs	0245-275 lbs
o over 165 lbs	o over 195 lbs	0 over 235 lbs	0 over 275 lbs

PART 1:

Check statements or symptoms that describe you:

- O Decreased sex drive or libido
- O Softness and/or decrease of muscle size
- O Changes in muscle tone
- O Decrease in muscle strength and endurance
- O Erections less strong
- O Less frequent nocturnal erections
- O Growth of breast tissue
- O Tender nipples
- O Loss of pubic or armpit hair
- O Slow or no facial hair growth
- O Diminished normal "pungent" body odor
- O Increased waist size
- O Loss of height

PART 2:

Check statements or symptoms that describe you:

- O Tend to tire easily
- O Grumpy, sad or moody
- O Recent deterioration in your ability to play sports
- O Falling asleep after dinner
- O Lack of energy
- O Low tolerance for stress and otherwise ordinary problems
- O More volatile than usual - "easy to anger"
- O Feel hostile
- O Anxious
- O Nervous and tense
- O Loss of confidence

PART 3:

Check statements or symptoms that describe you:

- O Difficulty absorbing information
- O Tend to forget things
- O Recent deterioration in your work performance
- O Trouble thinking or concentrating
- O Have more trouble solving problems or managing your time than usual

PART 4:

Check statements or symptoms that describe you:

- O Sensation of not emptying your bladder completely
- O Need to urinate less than 2 hours after you have finished urinating
- O Find it difficult to postpone urination
- O Have a weak urinary stream
- O Need to push or strain to begin urinating
- O Dripping after urination
- O Urge to urinate several times a night

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Past Medical, Holistic, Nutritional Testing Procedures and Results:

Date	Test/Procedure	Results

Amount of Water per day_____cups/liters Caffeinated Beverages_____ounces

Number of Bowel Movements per day/week (circle one)_____light brown dark brown green

Stools: well formed (in logs) loose constipated/hard watery diarrhea hemorrhoids polyps

Stomach aches Sensitive Stomach Gas/Bloating between meals Gas/Bloating immediately after meals

Diet: Vegan Vegetarian Mixed(animal and plant) Diabetic Diet other_____

Artificial Sweeteners use: aspartame sucralose saccharin corn syrup high fructose corn syrup

Number of Meals per week out at a restaurant/deli/fast food_____

Blood Type: O A B AB

Genetic Heritage:_____

Birth Defects:_____

Dental Health: dentures partials crowns bridges amalgam/metal fillings root canals "red toothbrush" puffy gums black gums bleeding gums mouth sores cold sores white tongue

Vision: surgically corrected_____ wear glasses/contacts vision deteriorating

Sinuses/Throat: Sinusitis Stuffy Nose Runny Nose Sneezing Mucus Surgery

Hearing: ringing/tinnitus loss of hearing plugged ears ear wax itchy ear canals

Immune System: Auto Immune Disease_____ Frequency of Cold/Flu_____

Allergies:_____

Concentration: difficulty diminishing can't multi-task memory get easily lost while driving

Skeletal: getting shorter arthritis bone pain osteoporosis other_____

Muscular: spasms weakness Charlie horse tires easily with little effort can't exercise

Cardiovascular: heart condition_____ rapid or slow heart rate pounding in chest while resting chest/shoulder/arm pain related to heart blue fingernails/lips/nose/ears hardening of arteries

Reproductive and Bladder: ovary/testes trouble uterus/prostate trouble fertility trouble

Feet/Ankles: dropped arches high arches deformed toes, foot or ankle orthotics

Joints or other body parts replaced or transplanted_____

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Medications:

Date Prescribed	Medication	Diagnosis

Nutritional Vitamin Supplements/Herbs/Homeopathic Remedies:

Supplement Name	Duration of Use	Reason

Anything else you would like the doctor to know?

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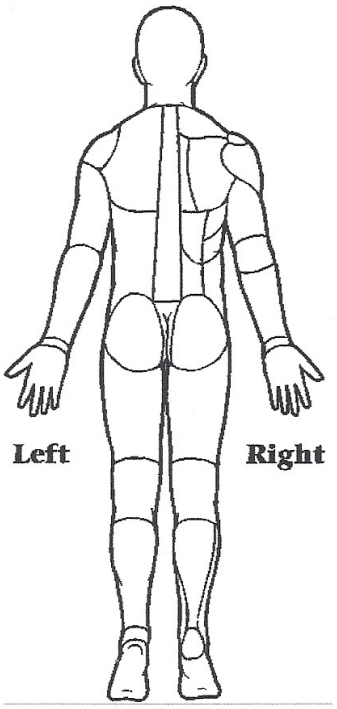
Health and Wellness Center
Where Better Health Happens

Pain Chart (full body)

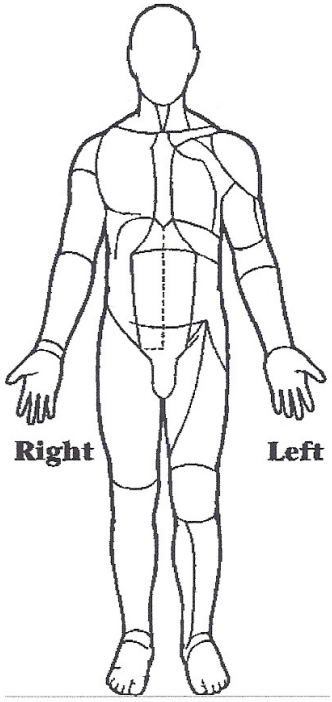
Pain Representation
Ache V V V V V V V V V V V V V
Burning = = = = = = = = = = =
Numbness o o o o o o o o o o o o o o o o
Pins & Needles ● ● ● ● ● ● ● ● ● ● ● ● ●
Stabbing / / / / / / / / / / / / / / / / /
Other x x x x x x x x x x x x x

Patient's Name

Draw location and type of pain on the body outline and mark the degree on the pain line at the bottom of the page.



Back



Front

No Pain **Worst Pain Possible**

Please make a slash through this line to indicate the level of your pain.

Patient's Signature Date

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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.

To be completed by patient or by patient's representative if necessary, e.g., if patient is a minor or physically or legally incapacitated:

_____ _____

Print Patient's Name Signature of Doctor Date

_____

Signature of Patient or Patient's Representative Date

_____ _____

Print Patient's Representative's Name Representative's Relation to Patient

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Financial Agreement

Cash Payment

We would like to take a moment to welcome you to our office and assure you that you will be receiving the very best care available.

In order to familiarize you with the financial policies of our office, I would first like to explain how your medical bills will be handled.

It is our policy in this office to maintain your account on a current basis. Charges for consultation, examination, treatment, supports and nutritional supplements are due at the time the service is provided.

If this arrangement is becomes a problem for you, please see our office manager so that other arrangements can be made for you.

If you need any reports or forms completed by the doctor, a customary fee for such reports or forms will be charged in addition to the normal fees for services. You will be notified of any additional charge prior to the doctor writing any reports or forms.

Our policy requires you give us 48 hours notice to cancel an appointment so that we have time to give this appointment to someone else. We have a $65 missed appointment fee.

It is also the policy of this office that if you should suspend or terminate your care or treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

Once again, we'd like to welcome you to our office. If you have any questions at any time, please don't hesitate to ask.

I have read and understood the above agreement between the office and myself.

_____ _____

Patient's signature date

_____

Patient's name printed

_____

Parent/Guardian's name printed

_____

Parent/Guardian's signature

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