



BACK TO FUNCTION

2383 LOMITA BLVD. SUITE 115
LOMITA, CA. 90717

NAME _____ HOME PHONE(_____)_____

ADDRESS _____ BUSINESS PHONE(_____)_____

CITY/ZIP _____ PAGER/CELL PHONE(_____)_____

E-MAIL _____ @ _____ BIRTH DATE ___/___/___ AGE _____ SEX: M / F

SOCIAL SECURITY# _____ REFERRED BY _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ CITY/ZIP _____

INSURANCE PLAN _____ POLICY# _____

GROUP# _____ RELATIONSHIP TO INSURED: SELF SPOUSE DEPENDENT

IF SPOUSE OR DEPENDENT: INSURED'S NAME _____

INSURED'S SOCIAL SECURITY# _____ INSURED'S BIRTH DATE ___/___/___

CONTACT IN CASE OF AN EMERGENCY: NAME _____ PHONE(_____)_____

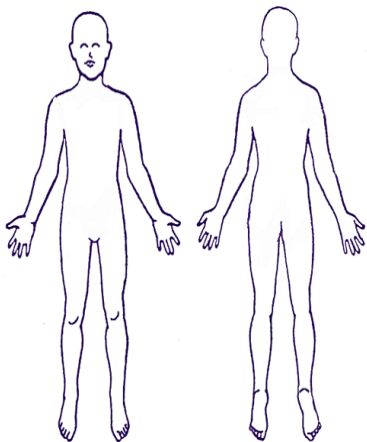
IS THIS A WORKER'S COMPENSATION CASE? YES NO

IS THIS A PERSONAL INJURY CASE? YES NO

IS THIS INJURY A RESULT OF A MOTOR VEHICLE ACCIDENT? YES NO

DESCRIBE AREA OF COMPLAINT _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Current complaint (how you feel today):										
0	1	2	3	4	5	6	7	8	9	10
No pain							Unbearable pain			

How often are your symptoms present? 0 – 25% 26 – 50% 51 – 75% 76 – 100% of time

Have you had x-rays, MRI or any other type of imaging? no yes Date(s) taken: _____

Are you seeing any other physician of any type, for any reason? _____

Who did your last physical exam and when was it? _____

Family history of:

Cancer Diabetes High blood pressure Cardiovascular problems or stroke

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Heart attack, coronary bypass or other cardiac surgery | <input type="checkbox"/> none apply |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer or tumor |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Unusual shortness of breath |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Light-headedness or fainting |
| <input type="checkbox"/> Phlebitis or emboli | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chest discomfort | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Extra, skipped, or rapid heart beats or palpitations | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Chronic recurrent cough |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Increased anxiety or depression |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Emotional disorders |
| <input type="checkbox"/> Migraine or recurrent headaches | <input type="checkbox"/> Fatigue or lack of energy |
| <input type="checkbox"/> Swollen, stiff or painful joints | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Foot problems | <input type="checkbox"/> Stomach or intestinal problems |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Shoulder problems | <input type="checkbox"/> Limited range of motion in joints |
| <input type="checkbox"/> Neck problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Corticosteroid use | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Urinary retention or prostate problems | <input type="checkbox"/> Numbness in groin or buttocks |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Aortic aneurysm |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Pregnancies_____ Births_____ |
| | <input type="checkbox"/> Drug abuse |

If you checked any of these, please explain here: _____

How active do you consider yourself? (Please circle)

Sedentary Lightly active Moderately active Highly active

Are you presently involved in a regular exercise program? If yes, please list activity, duration, frequency, and intensity: _____

Please describe your knowledge of exercise and fitness. (Please circle)

Good Fair Poor

Are you now, or have you been on a diet? Yes No

(a) If yes, explain.

Do you consider yourself overweight or underweight? (If yes, please circle which)

How would you describe your nutrition habits? (Please circle)

Good Fair Poor

How many of the following do you eat every day? Meals ____ Fruits ____ Vegetables ____ Green salads ____
Fish ____ Fried foods ____ Fast foods ____ Red meat ____ Dairy foods (milk, cheese, butter)? ____

List any foods you do NOT like to eat: _____

Please list any medications or dietary supplements you are now taking. _____

How would you characterize your life? (Please circle)

Highly stressful Moderately stressful Low in stress

Please check specific goals.

- | | |
|---|---|
| <input type="checkbox"/> Improve strength | <input type="checkbox"/> Reduce stress |
| <input type="checkbox"/> Improve flexibility | <input type="checkbox"/> Increase energy |
| <input type="checkbox"/> Improve cardiovascular fitness | <input type="checkbox"/> Get rid of current pain |
| <input type="checkbox"/> Improve muscle tone and shape | <input type="checkbox"/> Injury prevention |
| <input type="checkbox"/> Improve diet/eating habits | <input type="checkbox"/> Rehabilitate injury |
| <input type="checkbox"/> Lose weight | <input type="checkbox"/> Improve speed |
| <input type="checkbox"/> Gain weight/muscle | <input type="checkbox"/> Additional goals (list): _____ |

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 and/or other licensed doctors of chiropractic who now or in the future work 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 that results are not guaranteed.

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 risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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.

PATIENT/ATHLETE SIGNATURE _____ DATE ____/____/____

GUARDIAN'S SIGNATURE (FOR MINORS) _____ DATE ____/____/____

For Office Use Only

The patient has been notified of the possible risks, alternatives to and complications of our treatment approaches.

All questions were answered. Doctor initials: _____ Date: _____