CHIRO WELLNESS
2149 E. Garvey N, Suite A-5
West Covina, CA 91791
(626) 233-6366

Name (Last, First, M.I)_____Preferred Name_____

Address_____City_____State____ Zip_____

Best phone number to reach you: _____-_____-_____. Are you insured? Yes _____ No _____

E-mail_____ Social Security Number_____-_____-_____

Sex: M F Age_____ Date of Birth_____ Marital Status: M S W D How many children___ Ages_____

Employer_____Occupation_____

Employer's Address_____Phone_____

Person to Contact in case of Emergency: Name_____Phone_____

Relationship_____**How were you referred to our office?_____**

My Health is: □Always a top priority □Low priority □Only a priority when I'm sick

Office Policy: Financial Responsibility

Deductibles, nutritional supplements, orthotics and any non-covered insurance or private pay item/services are due in full at the time the service is rendered. Your insurance company will be billed as a courtesy to you with the information provided by you. If insurance payment is received by the patient, payment and explanation of benefits (EOB) is expected within five (5) days in order to properly credit your account.

Repeated no shows, or last minute cancellations may result in premature discharge of the patient (at doctor's discretion) and/or be subject to a $25 service charge. There is a $**25.00** service charge for all returned checks.I have read and understand the above terms and conditions and by executing this document with my signature below, I give authorization to Core Fit Rehab and I do hereby accept and agree to all of the terms and conditions outlined.

CONSENT TO TREATMENT

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.Although spinal manipulation/adjustment is considered to be one of the **safest**, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. _____ **(Initial)**Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare**._____ (Initial)** Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution**._____ (Initial)** Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. _____**(Initial).Physical Therapy Burns**: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits**._____(Initial)**I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. _____**(Initial).**I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM and FINANCIAL RESPONSIBILITY. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of patient _____ Signature of parent/guardian

_____Date

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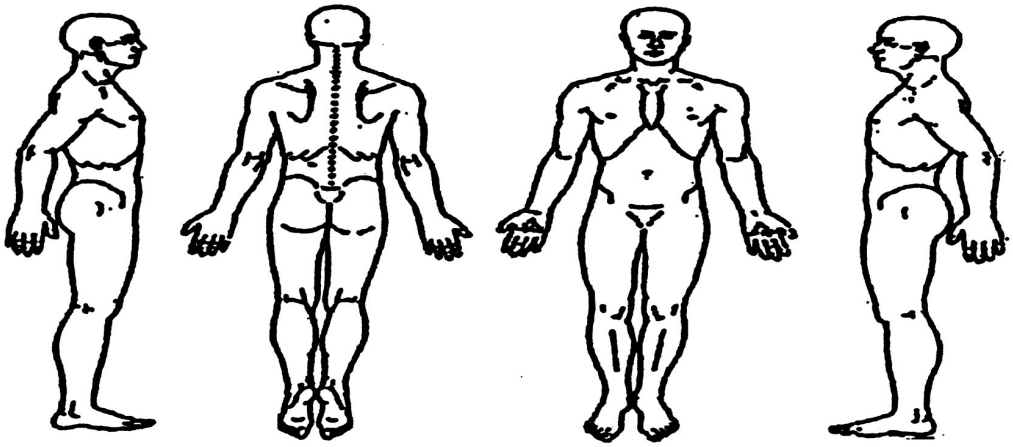
PATIENT INTAKE FOR Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain, discomfort or symptoms?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ No one □ Other:_____

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What alleviates the problem?

_____

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15. What concerns you the most about your problem; what does it prevent you from doing?
_____

15. What is your: Height_____ Weight _____ Date of Birth _____
Occupation _____
16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor
17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None
18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Other:_____
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination	Other:_____	
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?
□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day
□ **Other**:_____

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

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26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____