



HEALTH TEAM

<p style="text-align: center;">About the Patient</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Home Phone () _____</p> <p>Cell Phone () _____</p> <p>Birth date _____ Age _____</p> <p>Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Number of Children _____</p> <p>Employer _____</p> <p>Work Address _____</p> <p>Work Phone () _____</p> <p>Type of Work _____</p> <p>Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed</p> <p>Social Security# _____</p> <p>E-mail Address _____</p> <p>Payment Method <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit</p> <p>Credit Card # _____ Exp ___/___ Code _____</p>	<p style="text-align: center;">Reason For This Visit</p> <p>Describe the purpose of this visit: _____</p> <hr/> <p>Is the purpose of this appointment related to:</p> <p><input type="checkbox"/> Home Injury <input type="checkbox"/> Auto <input type="checkbox"/> Sports <input type="checkbox"/> New (Acute) Condition <input type="checkbox"/> Job <input type="checkbox"/> Fall <input type="checkbox"/> Chronic Condition</p> <p>Please explain _____</p> <p>When did this condition begin? _____</p> <p>Has this condition: <input type="checkbox"/> Gotten Worse <input type="checkbox"/> Stayed Constant <input type="checkbox"/> Comes and goes</p> <p>Does this condition interfere with</p> <p><input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Other Activities</p> <p>Please Explain _____</p> <p>Have you had this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain _____</p> <p>Have you seen other doctors for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dr.'s Name _____</p> <p>Type of Treatment _____</p> <p>Results _____</p>
<p style="text-align: center;">About the Spouse or Parent</p> <p>Name _____</p> <p>Employer _____</p> <p>Work Address _____</p> <p>Work Phone () _____</p> <p>Type of Work _____</p>	<p style="text-align: center;">Emergency Contact</p> <p>Name _____</p> <p>Relationship _____</p> <p>Work Phone _____</p> <p>Home Phone _____</p>
<p style="text-align: center;">Experience With Chiropractic</p> <p>Who referred you to this office? _____</p> <p>Have you been adjusted by a Chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Reason for those visits? _____</p> <p>Doctor's Name _____</p> <p>Date of last visit? _____</p> <p>Has any <i>adult</i> in your family seen a Chiropractor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has any <i>child</i> in your family seen a Chiropractor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Awareness of Chiropractic Principles

Were you aware that...

- Doctors of Chiropractic work with the nervous system? Yes No
- The nervous system controls all bodily functions and systems? Yes No
- Chiropractic is the largest natural healing profession in the world? Yes No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

Health Conditions

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Alcohol/Drug Abuse
<input type="checkbox"/> Allergies
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain
<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chest Pain/Conditions
<input type="checkbox"/> Cold Extremities
<input type="checkbox"/> Cramps
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Digestion Problems
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ears Ring
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Headache
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Loss of memory
<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Lumps In Breast
<input type="checkbox"/> Neck Pain or Stiffness
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Poor Posture
<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Sciatica
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Sleep problems or Insomnia
<input type="checkbox"/> Spinal Curvatures
<input type="checkbox"/> Stroke
<input type="checkbox"/> Swelling of ankles
<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Other: _____ |
|---|---|---------------------------------------|

For Women Only:

- Are you pregnant? Yes No
- Are you nursing? Yes No
- Are you taking birth control?
 Yes No
- Do you experience painful Periods?
 Yes No
- Do you have irregular cycles?
 Yes No

Health Habits

- Do you smoke? Yes No
- Do you drink alcohol? Yes No
- Do you drink coffee? Yes No
- Do you exercise regularly? No Moderate Daily
- Do you wear Heel Lifts Sole Lifts
 Inner Soles Arch Supports

Medications I Take

- | | |
|--|---|
| <input type="checkbox"/> Pain Killers
<input type="checkbox"/> Muscle Relaxers
<input type="checkbox"/> Blood Pressure Medicine
<input type="checkbox"/> Insulin
<input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Stimulants
<input type="checkbox"/> Nerve Pills
<input type="checkbox"/> Tranquilizers
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |
|--|---|

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care:** Symptomatic relief of pain or discomfort
- Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
- Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the type of care appropriate for my condition.

Patient Signature

Date

Informed Consent for Chiropractic Treatment and Care

I Hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with San Diego Chiropractic Doctors.

I understand that, as in the practice of medicine, in the practice of chiropractic care 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. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with San Diego Chiropractic Doctors to perform such. 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.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payments. I agree that I am responsible for all the bills incurred at this office.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Patient Signature

Date

Guardian or Spouse's Signature

Date

Who should receive bills for payment on your account?

- Patient Spouse Parent Worker's Comp
 Medicare Personal Health Insurance Auto Insurance

X-Ray

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-rays only. The X-Ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

In an effort to bring our patients optimal health care, our x-rays are read by a board certified radiologist.

Dr. Cliff Tao, DC DACBR

Diplomate American Chiropractic Board of Radiology

Should you have x-rays we will be sending them to Dr. Tao for reading.

There is a charge of **\$25.00** for this service!

Please verify that you have read and understand this by signing the line below.

Patient Signature

Date

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt.

Insurance Company _____

Policy # _____

Address _____

Group # _____

Phone Number _____

About the Insured Person

Name _____

Insured Social Security # _____

Relation _____

Date of Birth _____

