Date_____

CHIROPRACTIC
NEW PATIENT QUESTIONAIRE

Chiropractic Rehabilitation WELLNESS CENTER

NAME_____**Birthdate**_____ **Age**_____

Address_____**City**_____**State**_____**Zip**_____

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

Sex: M F Marital Status: M S D W Name of Spouse_____**#Children**____

Occupation_____**Employer**_____

Describe Duties:_____

What kind of Activities/Hobbies?_____

Referred By_____**Do you have HEALTH INSURANCE?**_____

Is this a WORK INJURY?_____**Have you been in an AUTOMOBILE ACCIDENT?**_____

( ) Past Year ( ) Past 5 years ( ) Over 5 years Describe Accident:_____

Other Personal Injuries or Accidents?_____**Please describe:**_____

PURPOSE OF THIS APPOINTMENT (Major Complaint)_____

_____

OTHER COMPLAINTS:_____

When did this start?_____**What did you do to hurt yourself?**_____

Describe the pain…Sharp, Dull, Burning, Throbbing, etc._____

Is the pain constant or does it come and go? If it comes and goes, how often does it hurt?_____

Have you ever had this problem before? When?_____

Do you have any pain in the shoulders, arms or legs or any tingling or numbness? Where?_____

Can you find a comfortable position which seems to relieve your symptoms? What is it?_____

Have you done anything for this? Heating Pad?_____**Help?**_____
Ice?_____**Help?**_____
Aspirin, Advil, Tylenol?_____**Help?**_____
Ben Gay, Deep Heat, Icy Hot:_____**Help?**_____

Is this so bad you can't work? YES NO Does it slow you down at work? YES NO

Does it keep you from sleeping? YES NO

Which activities aggravate your condition?

( ) Walking ( ) Sitting ( ) Standing ( ) Sleeping ( ) Bending ( ) Other:_____

Does it keep you from doing anything that you want to do? _____

How does it affect you? _____

Is this condition getting progressively worse: ( )Yes ( )No ( )Constant

Is this condition interfering with your ( )Daily Routine ( )Other:_____

OTHER COMPLAINTS:_____

Have you had previous CHIROPRACTIC CARE: ( )YES ( )NO ACUPUNCTURE CARE: ( )Yes ( )No

Name of Previous Chiropractor or Acupuncturist:_____

Have you seen a Medical Doctor or other Practitioner about this condition? ( )YES ( )NO

If so, what was the diagnosis? _____

What was the treatment? _____

Medications? _____

Date of Last Visit with Physician:_____Name of MD:_____

Address:_____Phone:_____

CURRENT MEDICATIONS:_____

_____

SURGICAL HISTORY:_____

_____

Please indicate if you have any of the following conditions; certain medications and health problem may be contraindicated for massage. If necessary, a physicians release may be required from your primary care provider.

	Yes	No	Additional Information
Arthritis	____	____	
Diabetes	____	____	**Type I or Type II_____**
Frequent Headaches	____	____	**How Often_____**
High Blood Pressure	____	____	
Epilepsy or Seizures	____	____	
Joint Swelling	____	____	**Where_____**
Varicose Veins	____	____	**Where_____**
Contagious Disease	____	____	**Explain_____**
Osteoporosis	____	____	
Allergies	____	____	**To What_____**
Back Pain	____	____	
Knee Pain	____	____	
Other Joint Pain	____	____	**Where_____**
Surgery	____	____	**For What_____**
Frequent Numbness or Tingling	____	____	**Where_____**
Pregnant	____	____	**How far along_____**
Recent Injury	____	____	**Explain_____**
Allergy to Lotion or Oils	____	____	**What Type_____**

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU MAY SUFFER FROM NOT LISTED ABOVE_____

_____

SIGNATURE OF PATIENT (OR GUARDIAN)_____DATE_____

Emergency Contact _____Phone_____

CONSENT TO TREAT AND ASSIGNMENT OF BENEFITS

I hereby authorize Rick L. Barrack, D.C., Daniel C. Postulka, D.C., Craig E. Heller, D.C., Gianne Brintwood, D. C. and/or Nima Arabani, D.C., L.Ac. to examine and treat me. I hereby request and consent to the performance of procedures, which may include but is not limited to various modes of physical therapy, diagnostic x-rays, and/or chiropractic adjustments on me (or the patient named below, for whom I am legally responsible) by the doctor named below and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back up for the above mentioned doctors and Chiropractic Rehabilitation WELLNESS CENTER.

I understand and am informed that in the practice of medicine and in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disk 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 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 the 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.

I request that payment of authorized benefits be made either to me or on my behalf to the above mentioned doctors for any services furnished me by that doctor. I authorize any insurance company or any government agency and its agents any information needed to determine these benefits or the benefits payable for related services. I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that verification of insurance benefits is not a guarantee of payment. I understand that I am financially responsible for all charges, whether or not paid by said insurance company. I hereby authorize said assignee to release all medical information necessary to secure payment, including copies of chart notes.

This Assignment will remain in effect until revoked by me in writing. A photocopy of this Assignment is to be considered as valid as an original. If patient is a minor, who is the responsible party? _____

TO BE COMPLETED BY PATIENT

Patient's Name:_____ Signature of Patient:_____

Date Signed:_____ Witness or Patient's Guardian Signature_____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name:_____ Signature of Patient:_____

Date Signed:_____ Representative's Signature_____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Office: Chiropractic Rehabilitation Wellness Center Address: 115 Main Street, Vista, Ca. 92084
Name of Chiropractor's treating this Patient:

1. _____ PIN# _____
2. _____ PIN# _____
3. _____ PIN# _____