BACK TO FUNCTION
2383 LOMITA BLVD. SUITE 115
LOMITA, CA. 90717

NAME_____ HOME PHONE(_____)_____

ADDRESS_____BUSINESS PHONE(_____)_____

CITY/ZIP_____CELL PHONE(_____)_____

E-MAIL_____@_____BIRTH DATE____/____/____AGE_____SEX: M / F

HEIGHT_____WEIGHT_____DOMINANT HAND? R L

LAST 4 DIGITS OF SSN: xxx-xx-_____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(____)_____

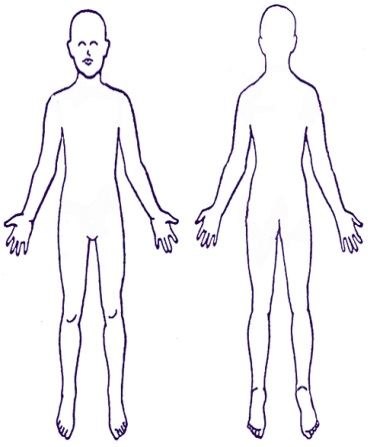
IS THIS A WORKER'S COMPENSATION CASE? YES NO

IS THIS A MOTOR VEHICLE ACCIDENT OR PERSONAL INJURY CASE? 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: □ none apply

□Heart attack, coronary bypass or other cardiac surgery
□Diabetes
□Stroke
□Peripheral vascular disease
□Phlebitis or emboli
□Rheumatic fever
□High blood pressure
□Chest discomfort
□Extra, skipped, or rapid heart beats or palpitations
□Heart murmur
□Ankle swelling
□Trouble sleeping
□Migraine or recurrent headaches
□Swollen, stiff or painful joints
□Foot problems
□Back problems
□Shoulder problems
□Neck problems
□Corticosteroid use
□Birth control pills
□Urinary retention or prostate problems
□Frequent urination
□Tuberculosis
□Alcohol abuse
□Cancer or tumor
□Unusual shortness of breath
□Light-headedness or fainting
□Epilepsy or seizures
□Anemia
□Asthma
□Emphysema
□Pneumonia
□Chronic recurrent cough
□Increased anxiety or depression
□Emotional disorders
□Fatigue or lack of energy
□Ulcers
□Stomach or intestinal problems
□Hernia
□Limited range of motion in joints
□Arthritis
□High cholesterol
□Broken bones
□Numbness in groin or buttocks
□Aortic aneurysm
□Osteoporosis
□Pregnancies_____ Births_____
□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.

- □Improve strength
- □Improve flexibility
- □Improve cardiovascular fitness
- □Improve muscle tone and shape
- □Improve diet/eating habits
- □Lose weight
- □Gain weight/muscle
- □Reduce stress
- □Increase energy
- □Get rid of current pain
- □Injury prevention
- □Rehabilitate injury
- □Improve speed
- □ 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: _____