Patient Name _____ Address_____ Gender: M F
City _____ State_____ Zip code_____ E-mail _____
Home _____ Work _____ Mobile _____
Mobile Provider_____
Best number and time to reach you? _____

Date of Birth _____ Social Security # _____

To better serve you please answer the following questions:

1. What are your health goals? _____
2. How do you expect to achieve them? _____
3. Addressing what brought you into this office: (If you have no symptoms or complaints and are here for wellness services, please skip to question 5.)

Please list your health concerns according to their severity	Level of severity 1 – Mild 10 - Severe	When did this episode start?	Have you had this condition before? If so, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

4. Check off the following symptoms or disorders you have and CIRCLE the ones that affect you the most:

Headache/Migraines	Neck Pain	Hip Pain (right or left)	Chemical Stress
Allergies	Shoulder Pain (right or left)	Knee pain (right or left)	Physical Stress
Chest/Rib Pain	Elbow Pain (right or left)	Ankle Pain (right or left)	Emotional Stress/Anxiety
Dizziness	Wrist Pain (right or left)	Muscle Stress	Attention Disorders
Ear Aches	Scoliosis	Constipation	Sciatica
Asthma	Low Back pain	Hyperactivity	Numbness/Tingling
Frequent Colds/Flu	Mid-Back Pain	Arthritis	Leg pain (right or left)
Heartburn/Reflux	Disc Problems	Arm pain (right or left)	Vertigo
Low Energy/Fatigue	Insomnia	Depression	Ulcers
Weight Gain	Ringing/Buzzing in Ears	Bed Wetting	Autoimmune Disease
Loss of Memory	High Blood Pressure	Menstrual Problems	Diabetes
Excess Gas/Bloating	Low Blood Pressure	Thyroid Trouble	Swollen Ankles
Multiple Sclerosis	Fibromyalgia	Circulatory Problems	Skin Conditions/Acne
High Cholesterol	Shortness of Breath	Nausea	Diarrhea
Bladder Problems	Cancer	Vascular Disorder	Urinary Difficulty
Digestive Problems	Heart Condition	Immune System Disorder	Sinus Trouble
Infertility	Kidney Disease	Mood Swings	Osteoporosis

Other:_____

Which pain or condition is the worst? _____

What do you believe is the cause? _____

What are you currently doing for it? _____

How long has this condition bothered you? _____

Is your pain sharp or dull? _____

Do you feel constant or occasional pain? _____

Pressure on the spinal cord or nerves can be worse in the AM or the PM. Which is harder for you? _____

Does this radiate to an extremity or stay in one area? _____

(5a) Are any of the above symptoms linked to a current car accident or workers compensation case? _____

6. Please indicate which areas of your life are compromised by your current level of health:

Bending	Housework	Relationships with Friends
Lifting	Yardwork	Overall sense of wellbeing
Walking	Travel	Family Relationships
Sitting	Energy Levels	Way I handle Stress
Climbing Stairs	Job Activities	Overall Moods
Standing	Emotional Well-Being	Patience and Temper
Running	Recreational Activities	Relationship with Significant Other
Exercise	Memory	Relationships with friends Productivity
Concentration and Focus	My patience and temper	Sports and Physical Activities
Weight and Metabolism	Relationships with Kids	

7. Are you bothered by: (Check all that applies)

____ Anxiety ____ Depression ____ Irritability

8. On a scale of 1-10:
   a. Where would you rate your overall health and well-being? _____
   b. Where would you want it to be? _____ And how long do you think this process will take? _____

9. Have you had any experience with chiropractic? YES NO
   a. Did you like the results? YES NO
   b. What did you enjoy most and least about your visits there? _____

How were you referred to us? _____
Employer_____

Occupation (Please be specific. The work we do can greatly affect our health and/or stress level. This information will help the doctor with your course of care)

_____

Circle one: Single Married Divorced/Separated Widowed

Name of Spouse _____

Name of children and age(s) _____

Education completed: High school College Graduate Post-Graduate

Medical History

List all physicians and practitioners you have seen for your **current** condition _____

_____

Have you had any surgeries? YES NO If so, when and what? _____

_____

_____

Do you have any scars? YES NO If yes, where?_____
Do you currently have any injuries as a result of an auto or work related accident. If yes, please specify._____

_____

Have you ever been hospitalized? YES NO If yes, why? _____

List any medical conditions you currently have: _____

List any medications you are currently on: _____

If there was a way we can help you come off these medications would you be interested? YES NO

List any known allergies (food, inhalants, etc.) _____

Have you ever had any of the following diagnostic tests?

___X-rays ___MRI scans ___Bone scan ___CT scan ___Myelogram ___Disco gram ___EMG

If any reason selected, list reason:_____

Do you have a history of cancer? YES NO Are you currently pregnant? YES NO

Check all that apply:

___Smoker ___Non-smoker ___Drinks Alcohol ___Does not drink alcohol ___Takes drugs ___Does not take drug

SOCIAL/FAMILY MEDICAL HISTORY

___ Heart Disease _____ Stroke ____Circulatory Disorder _____ Blood Pressure ____ Diabetes

___ Other: _____

Health From Within Family Wellness Center

1818 Marron Rd, Suite 103, Carlsbad, CA 92008 760.385.8352

Informed Consent:

The chiropractic doctor provides a specialized, non-duplicating health care service which includes detecting and correcting spinal subluxations (a misalignment of one or more vertebrae causing a blockage in nerve flow). It is important to note that the chiropractic doctor cannot diagnose, treat or cure any disease, although the doctors of Health From Within Family Wellness Center are more than happy to work with other types of providers in your health care regimen.

I do hereby authorize the doctors of Health From Within Family Wellness Center to administer such chiropractic care that is necessary for my particular case. This may include consultation, examination, adjustments or any other chiropractic procedure, which is advisable and necessary for my healthcare. I shall have an opportunity to discuss all chiropractic care that shall be necessary for my particular case. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated, however, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic doctor. I acknowledge that no guaranties can be made with respect to my treatment, and regardless of the outcome, I shall be responsible for all costs associated with my care.

In considering the amount of chiropractic expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Health From Within Family Wellness Center, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than thirty (30) days overdue, I will incur interest on my past due balance of seven percent (7%) per annum. I further acknowledge and agree that Health From Within Family Wellness Center shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Health From Within Family Wellness Center

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I understand that Health From Within Family Wellness Center has video recording equipment in the office for training purposes and to ensure that I receive the best possible care and experience. By signing below, I give permission to Health From Within Family Wellness Center to video record my office visits. I shall have the option to revoke my consent upon giving written notice to the Office Manager.

Acknowledgement

I have been informed that upon request I can receive a copy of the privacy practices (HIPPA). I am aware that I have an opportunity to discuss my rights to privacy if I please.

Print Name: _____ ***Signature:*** _____ ***Date:*** _____

Additional Terms of Acceptance

We are committed to you, and helping you and your family to understand your health condition. In order to achieve this, the following is our policy regarding going over your x-ray results. Should the doctor determine & your test reveal that you have subluxation, nerve damage or dysfunction, or degeneration (or any other serious conditions on your x-rays), YOUR SPOUSE will be required to attend the immediately next scheduled doctor's visit to discuss your exam/x-ray findings. This is for your own safety and benefit, as we believe that it is crucial to have family support to help with your health.

Additionally, it is important to have your spouse in attendance due to vital nature of what will be discussed, including but not limited to the following:

1. Treatment choices and options.
2. Insurance or other financial arrangements.
3. Supportive home care.

Having your spouse in attendance will also prevent having to go over an x-ray/exam finding more than one time per patient, preventing unnecessary work and minimizing charges and costs to you. The Doctor is willing to contact any employers for excused absence needs. Your cooperation is appreciated.

I have read, understand, and agree to the above additional terms of acceptance.

Name:_____ Signature:_____ Date: _____

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Print Name: _____ Signature: _____ Date: _____

Communications:

In the event that we would need to communicate your healthcare information, to who may we do so?

Spouse: _____ Children: _____ Others: _____

*****FOR WOMEN ONLY*****

Pregnancy Release:

This is to certify that to the best of my knowledge **I am NOT pregnant** and the above and doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can harm a fetus (unborn child) in the early stages.

Date of last menstrual period: _____ **Signature**_____
Date:_____