REGISTRATION & HEALTH HISTORY

Date:_____

PATIENT INFORMATION

Patient Name: _____
Address:_____
City_____ State___ Zip_____
Primary phone#:_____
Alternate phone#:_____
E-mail: _____
Birthdate:_____ Age _____ M__ F__
Married__ Single__ Divorced__ Widowed__ #of Children__
If patient is a Minor, provide parent/guardian name(s):
_____
Occupation: _____
Employer/School:_____
Employer address: _____
_____
Employer Phone #:_____
Spouse's Name:_____
Spouse's Occupation:_____
Spouse's Employer: _____
Emergency Contact & #:_____
How did you hear about our office?_____
If found online, what site did you use?_____

INSURANCE INFORMATION

Insurance Co: _____
ID#_____
Claim#_____
Policy#_____

Assignment and release:
I certify that I, and/or my dependents, have insurance coverage with _____ and assign that all insurance benefits, if any, otherwise payable to me for services rendered be paid directly to Bert Vanderbliek DC or Arthur Crockam II DC.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I authorize the use of my signature on all insurance submissions. The above named doctor/s may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent is to remain in effect until further notice.

X_____ Date:_____

PATIENT'S CURRENT CONDITION

Reason for today's visit? _____
Is this condition due to an accident? Yes__ No__ Date _____ If yes, please complete personal injury form
When did your symptoms appear?_____
Please rate the severity of your pain from 1-10? (no pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable)
How often are you feeling pain? Constant__ Frequent__ Intermittent__ Occasional__
How would you describe your pain? Sharp__ Throbbing__ Burning__ Dull__ Tingling__ Aching__ Gripping__
Other_____
Are you experiencing any? Numbness__ Weakness__ Soreness__ Stiffness__ Swelling__ Cramping__
What activities are painful: Stand__ Sit__ Lying down__ Walk__ Bend__ Exercise__ Other_____
Does it interfere with your: Work__ Sleep__ Family Life__ Mood__ Daily routines__ Hobbies__ Other_____
Since your pain began, is your condition? Improving__ Getting Worse__ Staying the same__
What would you like to achieve from your care at our office?_____

HEALTH HISTORY

Who is your Primary care physician:_____
Have you been to a chiropractor before? Yes__ No__ If so, Dr's Name_____
When was your last adjustment?_____
Date of last: Physical exam_____ Spinal X-ray_____ MRI – CT – Bone scan_____
Please describe major injuries and any surgical procedures performed:_____
_____
Please list any prescription or over the counter medications &/or supplements you take on a regular basis: _____
_____
Have you been in any accidents? Yes___ No___ If so, When_____
What type? Auto_____ Occupational_____ Personal_____

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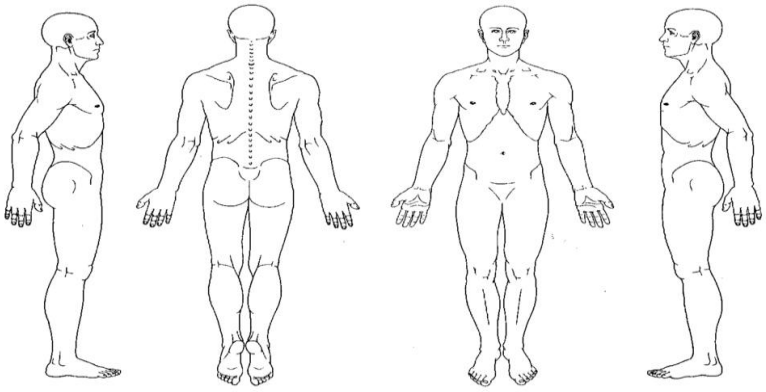
Office Use Only: ☐**A-List** ☐**Text** ☐**Email** ☐**SL#1** ☐**TY**_____

Mark an X on the areas on this body where you feel the described sensations. Also note (P)Pain (N)Numbness (T) Tingling



On a scale of 0 to 10, rate your level of discomfort

Neck-Shoulder-Arm-Pain
0 1 2 3 4 5 6 7 8 9 10
No Pain **Severe Pain**

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10
No Pain **Severe Pain**

Low Back and Leg Pain
0 1 2 3 4 5 6 7 8 9 10
No Pain **Severe Pain**

Please mark all conditions you have ever had, even if they don't seem relate to your current condition

- ☐ Headaches
- ☐ Migraines
- ☐ Jaw pain
- ☐ Neck pain
- ☐ Stiff neck
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Arm pain
- ☐ Finger pain
- ☐ Wrist pain
- ☐ Cold hands
- ☐ Elbow pain
- ☐ Leg pain
- ☐ Knee Pain
- ☐ Ankle pain
- ☐ Foot pain
- ☐ Pins/needles in arms & legs
- ☐ Numbness in finger & toes
- ☐ Cold feet
- ☐ Tension/Stress
- ☐ Nervousness
- ☐ Fatigue
- ☐ Irritability
- ☐ Vision problems
- ☐ Light bothers eyes
- ☐ Fainting/dizziness
- ☐ Loss of balance
- ☐ Problem sleeping
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Cancer _____
- ☐ Heart Attack/Stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hepatitis
- ☐ Gallbladder/Liver
- ☐ Irritable bowel syndrome
- ☐ Kidney disorder
- ☐ Heartburn
- ☐ Ulcers
- ☐ Upset stomach
- ☐ Excessive thirst
- ☐ Prostate problems
- ☐ Sinus Problems
- ☐ Ringing in ears
- ☐ High Fever
- ☐ Arthritis
- ☐ Asthma
- ☐ Colitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Problems urinating
- ☐ Cold sweats
- ☐ Hot Flashes
- ☐ Mood Swings
- ☐ Menstrual Pain
- ☐ PMS
- ☐ Menstrual irregularity

Female Patients:
Are you pregnant? Yes__ No__
Due date_____

PERSONAL LIFESTYLE

Exercise/sports:	**Work Habits:**	**Other Habits:**	
( ) none	( ) sitting	( ) Smoking	how often _____
( ) mild	( ) standing	( ) Drinking	how often _____
( ) moderate	( ) light labor	( ) Coffee/caffeine	how often _____
( ) heavy	( ) heavy labor	( ) Stress	Level 1-10 _____, Personal___ Occupational___

On a scale of Poor, Good, Excellent, describe your: Diet:_____ Sleep:_____ General Health_____
Weight:_____ Height: _____feet _____inches

YOUR CHILDHOOD YEARS

Did you have any serious illness/conditions? Yes__ No__ When? _____
Did you have any major surgeries/hospitalization? Yes__ No__ When? _____
Did you have any major falls/injuries? Yes__ No__ When? _____
Were you involved in a car accident? Yes__ No__ When? _____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention any health conditions or concerns you may have about your:
Spouse: _____
Children:_____
Parents: _____
Siblings: _____

I certify that the statements made on this form are complete and accurate to the best of my knowledge. I agree to notify the doctor immediately if I have any changes in my health condition.

Date_____ Patient Signature_____

Authorization for care of minor:

I herby authorize this office and its doctors to administer care to my son/daughter as they deem medically necessary.

Signature of Patient/Guardian _____ Relationship to minor_____

Name and address of clinic/office:	Name(s) of Doctor(s) treating this patient:
Family Wellness A Chiropractic Group **7439 Reseda Blvd.** **Reseda, CA 91335**	**Bert J. Vanderbliek_DC** **ArthurCrockam II DC**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

Print Patient's Name _____

I hereby request and consent to the performance of procedures which are within the scope of practice of chiropractic including, but not limited to, chiropractic adjustments, various modes of physical therapy and diagnostic x-rays, on me (or on the above named patient, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above 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 I am informed that there are some risks to chiropractic treatment, including but not limited to, fractures, disc injuries, stroke, 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 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 course of treatment for my present condition.

_____ _____

Signature of Patient or Patient's Representative | Print Name of Patient's Representative

_____ _____

Witness to Patient's Signature Date | Relationship or Authority Representative

_____

Translated by Date

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OUR POLICY OF CARE
AND PAYMENT FOR CASH PATIENTS

Providing high quality care is the goal of our practice

Payment is due at the time of treatment.

Payment can be made by **Cash**, **Check** or **Credit Card**
(Visa, Mastercard, American Express or Discover)

We also participate in the **CareCredit** program, which allows you to start your treatment today and spread payments over time. **CareCredit** –Applying for **CareCredit** only takes a few minutes and there is no fee to apply, applications are available at the front desk.

We realize it may be inconvenient to make payments at the time of each visit, therefore our office will be glad to set up a pre-pay plan for your convenience.

I have read and fully understand my responsibility concerning the payment for services rendered.

Date _____

Patient Name _____

Patient Signature_____