Chiropractic Wellness Group

969 E. Green Street, Pasadena CA 91106
(626) 584-WELL

CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of this form. If you need any help please ask the receptionist.

Social Security #: ________________

PATIENT DATA:

(First name, middle initial, last name) **Email:** ____________________________ **Cell Phone:** ____________________

Name___________________________ **Home Phone** ___________________ **Driver License #**________________

Home Address ______________________________ **City** ________________ **Zip Code** __________________

Mailing Address ____________________________**City** ________________ **Zip Code** __________________

Emergency Contact (Name & Number) ____

Age _____ **Date of Birth** ________________ **Marital: M S W D** **How Many Children?** _______

Occupation ____________________________ **Employer** ____

Employer's Address ____ **Office Phone** ___________________

Name of Spouse or Parent (circle one) __________________________ **Occupation**____________________

Spouse or Parents' Employer _____________________________**Office Phone** ___________________

Patient's Nearest Relative (other than Spouse) __________________ **Relationship** ___________________

Relative's Address ______________________________ **City** _______________ **Zip Code** _______________

How were you referred to our office? ____

Date of last physical exam ____

What operation have you had and when? ____

Serious illnesses ____

What Medication or drugs are you taking? ____

INSURANCE DATA:

Name of person(s) responsible for payment ____

Do you have insurance? ☐ **No** ☐ **Yes** **Company's Name** __________________________________

Please list all source of insurance:

- **Group Insurance** ________________________________ **Member No.** ____________________________
  Name
- **Spouse's Insurance**______________________________**Policy No.** ______________________________
  Name

I understand and agree that health and accident insurance policies are in an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I permit this office to endorse so-issued remittance for he conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable.

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 by the doctor or intern, affiliated with Chiropractic Wellness Group. I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks of treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect 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, and 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 Chiropractic Wellness Group to perform such. I intent this consent from to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature ___________________________ **Date:** ______________________

Guardian or Spouse's Signature Authorizing Care______________________ **Date:** ______________________

Information Taken By:______________________ **Date:** ______________________

-PLEASE COMPLETE THE INFORMATION ON THE REVERSE SIDE ALSO-

CHECK AREAS OF PAIN BELOW

SYMPTOMS:

HEAD:
- ☐ Headache
  - ☐ Entire head
  - ☐ Back of head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Ringing in ears

NECK:
- ☐ Stiff Neck
- ☐ Muscle spasms in neck
- ☐ Pain in neck
- ☐ Neck pain with movement

SHOULDER:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ Above shoulder level
  - ☐ Over head
- ☐ Tension in shoulders

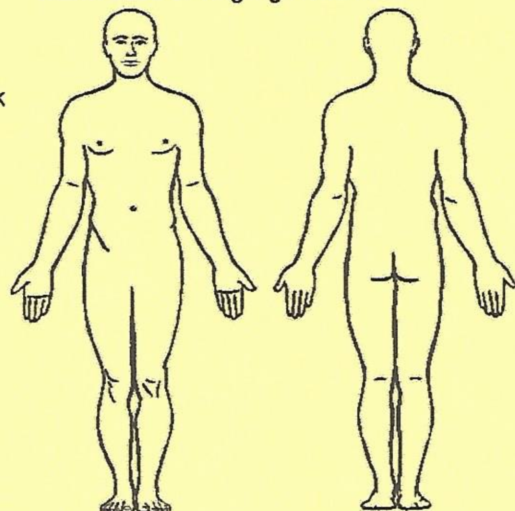
ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Finger go to sleep
- ☐ Hands cold
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp Stabbing pain in mid-back
- ☐ Muscle spasms

LOWER BACK
- ☐ Lower back pain
- ☐ Lower back pain in sores when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
- ☐ Lower back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)
- ☐ Pain down leg (R-L)
- ☐ Leg cramps
- ☐ Pins & needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Feet feel cold
- ☐ Cramps in feet (R-L)
- ☐ Swollen ankles (R-L)
- ☐ Swollen Feet (R-L)

Mark Areas of Pain
Mark Areas of Tingling/Numbness



CHEST:
- ☐ Chest pain
- ☐ Shortness of Breath
- ☐ Pain round ribs

GENERAL
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Loss of sleep
- ☐ Loss of weight

ABDOMEN:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea

Date of last menses ________________

Are you pregnant?
Yes No

Briefly describe symptoms you are presently suffering from: ____

____

Date symptoms appeared ________________ Have you lost any days work? From: ________ To: ________

Other Doctors seen for this / these condition(s): ____

____

POP, PD, PS, F/A. F/T, I/S, NOD, LOT, DOC, HP, NLW, DT, ADR, LFG

- **DO NOT WRITE BELOW THIS LINE** -

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FX ____

Prior Acc. ____

D.C.'s ____

Patient Accepted? ☐ Yes ☐ No Doctor's signature ________________________