BERNARDO WEST
CHIROPRACTIC

Get Healthy Now!

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI ____Date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email: _____

Birth Date: _____ Age _____ Sex: F M (circle one)

Occupation: _____ Employer's Name: _____

Work Address: _____ City/State/Zip: _____

Marital Status: S M D W Spouse's Name: _____ # of Children: _____

How were you referred to our office? _____

Do you have a Primary Care Physician? ❑ Yes ❑ No

Name: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Have you ever seen a Chiropractor before? ❑ Y ❑ N If Yes, When: _____

Where: _____ Results: _____

List other doctors who have treated this condition: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

WHY CHIROPRACTIC?

People go to chiropractors for a variety of reasons and there are different levels of care. **Check the box** of the type of care desired so that Bernardo West Chiropractic may be guided by your wishes whenever possible.

❑ ***Pain Relief***: Just get rid of the pain Doc! Relief is short-term.

❑ ***Rehabilitation***: Get rid of the pain, Doc, but then fix the *CAUSE* of this problem so that it doesn't come back!

❑ ***Optimal Health***: Get rid of the pain, fix the *CAUSE* of this problem, and then put me on an Optimal Health plan which includes, diet, exercise and chiropractic so that I stay as healthy as possible.

Print Name: _____ Signature: _____ Date: _____

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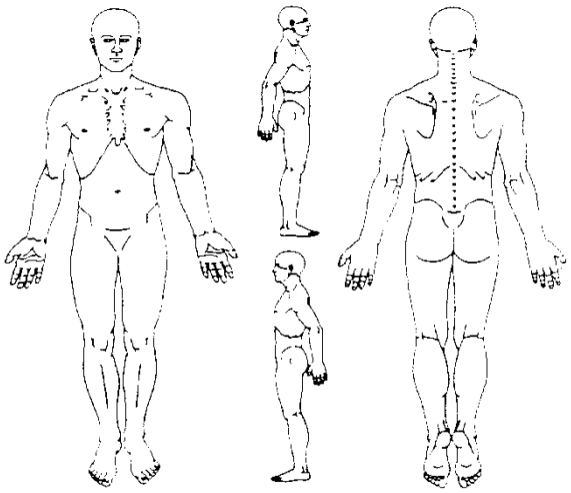
MAJOR COMPLAINT INFORMATION

Describe your current problem:

___ Neck Pain ___Upper/Mid-Back Pain ___ Headache

___ Sciatica/Thigh/Leg Pain ___ Shoulder/Arm/Wrist Pain Other _____

___ Numbness/Tingling ___ Low Back Pain _____



HOW did symptoms begin?

❑ Auto Accident ❑ Work Injury ❑ Other

Describe: _____

_____

_____

_____

_____

_____

_____

MARK AREAS OF PAIN ON FIGURES ABOVE

WHEN did symptoms begin? _____

Has this condition existed in the past? ❑ Yes ❑ No If Yes, When: _____

Is this condition getting: ❑ Worse ❑ Better ❑ Constant ❑ Comes & Goes

Current complaint: _____ _____

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

❑ 0-25% (Occasional) ❑ 26-50% (Intermittent) ❑ 51-75% (Frequent) ❑ 76-100% (Constant)

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other: _____

In the past week, how much has your pain interfered with your daily activities?

_____

0 1 2 3 4 5 6 7 8 9 10

No Interference Unable to carry on any activities

Print Name: _____ Signature: _____ Date: _____

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HEALTH HISTORY

Height: _____ Weight: _____ B/P _____ P: _____

Please check all of the following that apply to you:

❑ Alcohol/Drug Dependence ❑ Prostate Problems ❑ Epilepsy/Seizures
❑ Recent Fever ❑ Menstrual Problems ❑ Dizziness/Fainting
❑ Diabetes ❑ Urinary Problems ❑ Visual Disturbances
❑ High Blood Pressure ❑ Pain at Night ❑ Numbness in Groin/Buttocks
❑ Stroke (Date) ❑ Osteoporosis ❑ Pain Unrelieved by Position/Rest
❑ Birth Control Pills ❑ Marked Morning Pain/Stiffness ❑ Abnormal Weight ❑ Gain ❑ Loss
❑ Surgeries _____ ❑ Currently Pregnant, # _____ weeks
❑ Tobacco Use/ Type _____ Frequency _____ /Day ❑ Medications _____
❑ Corticosteroid Use (Cortisone, Prednisone, etc.) ❑ Cancer/Tumor (Explain): _____
❑ Other Health Problems (Explain) _____

Family History: ❑ Cancer ❑ Diabetes ❑ High Blood Pressure ❑ Heart Problems/Stroke ❑ Rheumatoid Arthritis

Imaging: Have you had Spinal X-RAYS, MRI, CT SCAN for your area of complaint? ❑ NO ❑ YES

Dates(s) Taken _____ What areas were imaged? _____

Check Those Activities Below During Which You Experience Difficulty or Pain

❑ Sitting ❑ Reaching ❑ Stooping ❑ Bending forward ❑ Turning over in bed
❑ Sneezing ❑ Gripping ❑ Walking ❑ Bending backward ❑ Lying flat on stomach
❑ Coughing ❑ Climbing ❑ Pushing ❑ Lying on back ❑ Lying on side with knees bent
❑ Reaching ❑ Dressing Self ❑ Pulling ❑ Getting in/out of car ❑ Standing for periods over one hour
❑ Other: _____

Mattress Type:
❑ Firm
❑ Medium
❑ Soft

Sleep Position:
❑ Left Side ❑ Right Side
❑ Stomach ❑ Back

Workstation:
Computer: ❑ Great ❑ Good ❑ Fair ❑ Poor
Chair: ❑ Great ❑ Good ❑ Fair ❑ Poor
Desk: ❑ Traditional ❑ Standing

Habits
❑ Smoking Packs/Day: _____
❑ Alcohol Drinks/Day: _____
❑ Coffee Cups/Day: _____
❑ Soft Drinks Drinks/Day: _____
❑ Water Glasses/Day: _____
❑ Vitamins List: _____

Exercise
❑ None
❑ 1-2 days/week
❑ 3-4 days/week
❑ 5 + days/week
Type _____

I certify to the best of my knowledge, 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 doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Print Name: _____ Signature: _____ Date: _____

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REVIEW OF SYSTEMS

Name: _____ Today's Date: _____

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you're not having any difficulties, please check "No Problems". If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Health in General ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness
Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Print Name: _____ Signature: _____ Date: _____

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INSURANCE INFORMATION

Primary Insurance Info:

Insurance Company: _____ Policy Holder's Name: _____

Relation to Patient: _____ Policy ID Number: _____

Group Number: _____

Do you have a Secondary Policy? ❑ **Yes** ❑ **No**

Insurance Company: _____ Policy Holder's Name: _____

Relation to Patient: _____ Policy ID Number: _____

Group Number: _____

FINANCIAL RESPONSIBILITIES

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all chiropractic and medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to BERNARDO WEST CHIROPRACTIC for all medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize BERNARDO WEST CHIROPRACTIC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from BERNARDO WEST CHIROPRACTIC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Print Name: _____ Signature: _____ Date: _____

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INFORMED CONSENT OF EXAMINATION/EVALUATION OF ALL PATIENTS

You are consenting to an examination by Dr. Jeff Oslance/Dr. Angela Hee by signing this form. Dr. Oslance/ Dr. Hee employ standard chiropractic examination methods including the following:

1) Observation: General assessment/ appraisal in all positions.
2) Inspection: Viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, back and side. All symptomatic (painful) body parts will be viewed.
3) Auscultation: Using stethoscope to listen for blood pressure and other body sounds.
4) Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, and modularity, laxity of tissues, integrity, and abnormality.
5) Percussion: using rubber hammer and tapping on bones or tendons
6) Orthopedic/neurological Testing: These are standard tests to access your neuro-musculo-skeletal systems.

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions. Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better. Although chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

NOTE: You do not have to submit to any examination procedure. I ask you to comply with the best of your ability and report changes in your pain. All procedures are accomplished to your tolerance.

I _____ understand the above statement and agree to submit to the above procedure and accept the risks and consequences of their application. I hereby authorize the doctors and staff affiliated with Bernardo West Chiropractic to treat my conditions as deemed appropriate.

_____ _____

Signature of Patient Date

PRIVACY PRACTICE

Patient's Written Acknowledgement of Doctor's Notice of Privacy Practices

I _____, acknowledge that I have read, fully understand and/or have had all my questions answered to my satisfaction regarding Bernardo West Chiropractic's Notice of Privacy Practices.

_____ _____

Patients Signature Date

_____ _____

Signature of Privacy Officer Date