Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ Date: _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ ☐ male ☐ female

Address: _____

_____

_____

Marital status

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Lenght of cycle: ____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? ____

How many children do you have? ____

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mamogram: _____

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

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Health Conditions

Abnormal ***postural habits or distortions*** are a result of trauma or stress (*physical, nutritional/chemical, or emotional*) to the body that have caused your body to adapt and misalign the vertebrae of your spine. When these vertebrae are twisted from their normal position and not ***Functioning*** (or moving) properly, they will cause stress to the nervous system (*which regulates ALL cells of the body*), spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called ***Subluxations.*** It has been extensively documented that subluxations decrease the natural motion & function of the spine, causing stress to your nervous system which weakens and distorts the overall structure of your spine. This results in a weakened and distorted ***Posture.*** Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called ***Forward Head Syndrome*** (**FHS** - a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). **Please check any health conditions you may be experiencing.**

- **Cervical Spine (Neck):** *Subluxations in your neck (causing **FHS**) will weaken the nerves into your arms, hands and head and can cause many conditions.* **Do you experience...?**

Past	Present	Past	Present	Past	Present
☐	☐ Neck Pain/stiffness	☐	☐ Headaches	☐	☐ Sinusitis
☐	☐ Shoulder/Elbow/Hand/Wrist Pain (R/L)	☐	☐ Allergies/Hay fever	☐	☐ Dizziness
☐	☐ Numbness/tingling in arm/hands (R/L)	☐	☐ Visual disturbances	☐	☐ Recurrent cold/flu
☐	☐ Hearing Disturbances (i.e. tinnitus)	☐	☐ Coldness in hands/feet	☐	☐ Weakness in grip
☐	☐ Thyroid conditions	☐	☐ High Blood Pressure	☐	☐ Fatique
☐	☐ Jaw Pain	☐	☐ Chronic Cough	☐	☐ Difficulty swallowing

- **Thoracic Spine (Upper Back):** *Subluxations in the upper back (resulting from **FHS**) will weaken the nerves to the heart and lungs And can cause many conditions.* **Do you experience...?**

Past	Present	Past	Present	Past	Present
☐	☐ Pain with deep inspiration/expiration	☐	☐ Asthma/wheezing	☐	☐ Upper back pain
☐	☐ Recurrent lung infections/bronchitis	☐	☐ Heart murmurs	☐	☐ Heart Palpitations
☐	☐ Heart attacks/Angina (date) _____	☐	☐ Shortness of breath	☐	☐ Tachycardia (fast heartbeat)

- **Thoracic Spine (Mid Back):** *Subluxations in the mid back (resulting from **FHS**) will weaken the nerves into your ribs/chest, upper digestive tract, and can cause many conditions.* **Do you experience...?**

Past	Present	Past	Present	Past	Present
☐	☐ Hypoglycemia (low blood sugar)	☐	☐ Mid back pain/stiffness	☐	☐ Nausea
☐	☐ Pain into your ribs/chest	☐	☐ Heartburn/Indigestion	☐	☐ Ulcers/gastritis

- **Lumbar Spine (Low Back):** *Subluxations in the low back (resulting from **FHS**) will weaken the nerves into your legs/feet, pelvic organs, and can cause many conditions.* **Do you experience...?**

Past	Present	Past	Present
☐	☐ Pain in your hips/legs/ankle/feet (R/L)	☐	☐ Recurrent bladder infections/painful urination
☐	☐ Numbness/tingling in legs/feet (R/L)	☐	☐ Frequent/difficulty urinating
☐	☐ Coldness in your legs/feet (R/L)	☐	☐ Constipation/irregular bowel habits (i.e. colitis)
☐	☐ Muscle cramps in legs/feet (R/L)	☐	☐ Menstrual irregularities/cramping
☐	☐ Weakness/injuries in your hips/knees/ankles	☐	☐ Low back pain/stiffness
☐	☐ Sexual dysfunction	☐	☐ Aortic Aneurysm

- **Other Conditions:** *All Subluxations weaken the nerves into your entire body and can cause many conditions.*
  Do you experience...?

Past	Present	Past	Present	Past	Present
☐	☐ Liver/Gallbladder problems	☐	☐ Depression	☐	☐ Rheumatoid Arthritis
☐	☐ Stroke (date) _____	☐	☐ STD(s)	☐	☐ Diabetes
☐	☐ Cancer (date) _____	☐	☐ Prostate Problems	☐	☐ Epilepsy
☐	☐ Tumor (explain) _____	☐	☐ Blood Disorders	☐	☐ Pregnancy, # births _____
☐	☐ Thyroid conditions	☐	☐ Emphysema	☐	☐ Hepatitis
☐	☐ Loss of bladder control	☐	☐ Arthritis	☐	☐ Kidney problems
☐	☐ Dermatitis/Eczema/Rash	☐	☐ Endometriosis	☐	☐ Abdominal Pain
☐	☐ Fainting	☐	☐ Convulsions	☐	☐ Abnormal weight gain/loss
☐	☐ Breast soreness/lumps	☐	☐ Profuse menstrual flow	☐	☐ Muscular incoordination
☐	☐ Chest pains	☐	☐ Loss of appetite	☐	☐ Eating Disorder

- **Please list any health conditions not mentioned:** _____
- **Please list any hospitalizations or surgeries:** _____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future. _____

New Practice Member's Signature Date

Patient Intake Form (side 2)

Give a breif detailed description of the problem you are currently experiencing: _____

_____

_____

_____

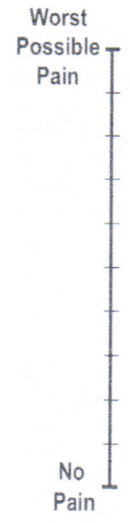
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

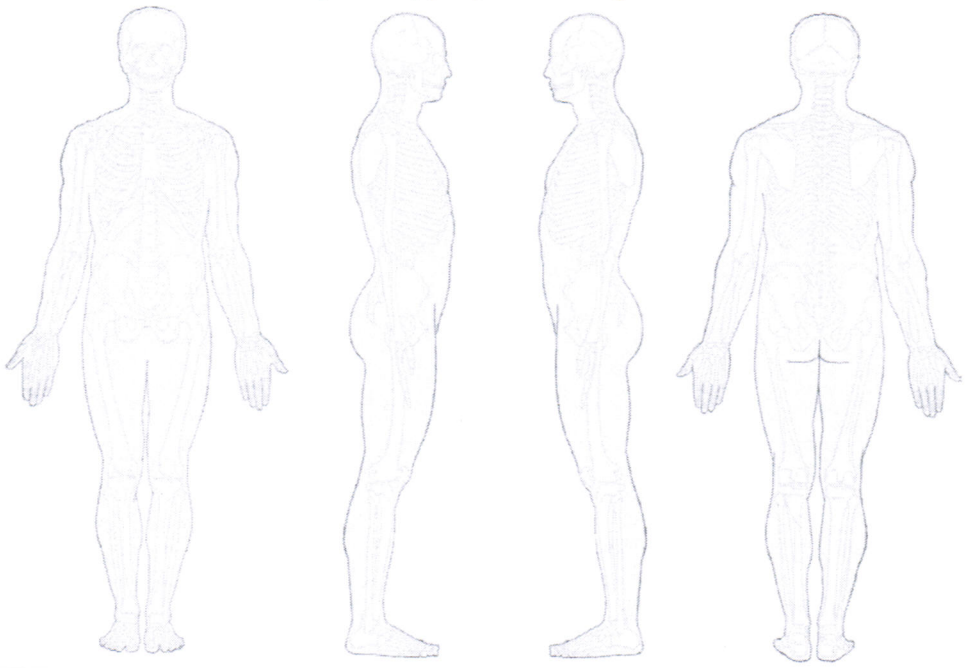
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your matress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- □ Alcoholism
- □ Anemia
- □ Arteriosclerosis
- □ Arthritis
- □ Asthma
- □ Bleed easily
- □ Cancer
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Heart disease
- □ High blood pressure
- □ High cholesterol
- □ Multiple sclerosis
- □ Osteoporosis
- □ Stroke
- □ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

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AUTHORIZATION OF CARE

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s), and physical therapy techniques on me (or on the person named below, for which I am legally responsible) for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I authorize the use of procedures above, which are recommended by the doctor(s) at Encino Wellness Center. ***I understand that I am responsible for all fees inquired for the services provided, and agree to ensure full payment of all charges.***

I understand that, as with any health care procedure, there are certain complications which may arise during chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor(s) of Encino Wellness Center to be able to anticipate all risks and complications and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure(s) which the doctor(s) feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor(s) of Encino Wellness Center and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the explanation of the chiropractic adjustment and related treatment by signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment.

The doctor(s) will not be held responsible for any other health conditions, or diagnosis, which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. ***I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from these programs***, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. *I authorize the assignment of all insurance benefits be paid directly to the doctor for all services rendered.*

_____	_____	_____
Practice Member's (PM) Name	*Signature of PM*	*Date*
_____	_____	
Parent/Guardian's Name	*Relationship to Applicant*	
_____	_____	
Parent/Guardian's Signature	*Date*	

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. *If this office chooses to bill any services to my insurance carrier, that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but* ***I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances.*** Any monies received will be credited to my account.

Name of Insurance Company _____ Provider Customer Service Phone# _____

Insured's Name _____ Insured SS# _____ Insured DOB _____

Insured ID/Subscriber # on card _____ Relationship to insured _____

Guardian/Spouse Authorizing Care _____ Date _____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with _____ (health care providers name).

Dated this _____ day of _____ 20___

_____
Patient signature (or Legal Guardian)
Print Name:_____

_____
Signature of Witness
Print Name:_____

Mednite

Sleep Assessment Worksheet

Name_____ **Date of Birth**_____

Best number to call you about these results: ( ) -

Email:_____

1. Do you snore?	Yes____	No____
2. Are you unable to stay awake in the daytime?	Yes____	No____
3. Do you wake up with a headache in the morning?	Yes____	No____
4. Do you wake up in the middle of the night unable to breathe or gasp for air?	Yes____	No____
5. Do your legs jerk at night or feel restless?	Yes____	No____
6. Do you have sudden episodes of loss of muscle control, especially during emotional situations?	Yes____	No____
7. Do you ever feel unable to move when falling asleep or waking up?	Yes____	No____
8. Have you gained a lot of weight in a short time?	Yes____	No____
9. Do you have problems falling asleep?	Yes____	No____
10. Do you have a hard time staying asleep?	Yes____	No____
11. Do you take any medications for sleep (Whether it is prescribed or off the counter)?	Yes____	No____

12. According to the fallowing scale, choose the appropriate number value to represent how likely you are to doze off or fall asleep during daytime in the following situations:

0 - Never 1 - Slight Chance 2 - Moderate 3 – Always

Sitting and reading	_____
Watching T.V.	_____
Sitting, inactive in a public place (i.e. Movie Theater)	_____
Sitting and talking to someone after lunch	_____
As a passenger for an hour in the car	_____
Driving a vehicle for two or more hours	_____
Lying down to rest in the afternoon when possible	_____

***Please Note:** We will evaluate this questionnaire and email you or contact you by phone. All information you have submitted will be strictly confidential. We never share information with other facilities. If deemed necessary, we will continue with a full nights scheduled sleep study.