WELCOME TO TWINS CHIROPRACTIC

Practice Member Name: ______________________________________Date:_________________ Age: _____ Birth date: _________________

Address: ____
Residence City State Zip Code

Home Telephone ( ) _______________________Cell Phone ( ) __________________________Male________ Female_______

Social Security # __________________________ Driver's Lic. # __________________________ **E-Mail**________________________________

Occupation____________________ Employer__________________________________ Work Phone ( )_________________________

Single______ Married ______ Divorced ______ Widowed______ Spouse's Occupation/Employer ___________________________

No. of children: ______ Emergency Contact__________________________________ Phone ( ) _________________________________

Can Dr. communicate with you through email? Yes No Would you like to receive our monthly newsletter? Yes No

Who may we thank for referring you to our office?
____

Your Health Information

What are your objectives in consulting our office?____

What other wellness professionals are currently a part of your health care team?

☐ Massage Therapist ☐ Acupuncturist ☐ Naturopath ☐ Homeopath ☐ Other____

How many Medical Doctor's office visits did you and your family have last year?

☐ None ☐ Less than 5 ☐ More than 5 ☐ More than 10

Have you had previous Chiropractic care? ☐ Yes ☐ No This year? ☐ Yes ☐ No

List previous surgeries and dates: ____

Medications: ☐ Pain Meds ☐ Birth Control ☐ Heart Meds ☐ Cholesterol Meds ☐ Other______________________________

Has a Doctor ever put you on a Wellness Program to improve your health? ☐ Yes ☐ No

If yes, did you follow the doctor's recommendations? ☐ Yes ☐ No

If no, would you be interested in a Wellness Program (Improving your Nutrition, Exercise and Stress Management) ☐ Yes ☐ No

Health History

Please check ( ) all of the following health concerns that you have experienced in the last five years, even if you think that your answers do not relate to your present health concern.

☐ Allergies
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Back Pain
☐ Bladder Problems
☐ Buzzing in Ears
☐ Cancer
☐ Circulatory/Vascular Problems
☐ Cold Feet
☐ Cold Hands
☐ Cold Sweats
☐ Constipation
☐ Depression
☐ Diarrhea
☐ Digestive Problems
☐ Dizziness
☐ Fainting
☐ Fatigue
☐ Headache
☐ Heartburn/Acid Reflux
☐ Heart Condition
☐ Hot Flashes
☐ Irritability
☐ Immune System Disorder
☐ Infertility
☐ Kidney Disease
☐ Loss of Balance
☐ Loss of Smell
☐ Loss of Taste
☐ Menstrual Cramps
☐ Menstrual Irregularity
☐ Mood Swings
☐ Neck Pain/Stiffness
☐ Nervousness
☐ Numbness in Fingers
☐ Numbness in Toes
☐ Osteoporosis
☐ Pins & Needles in Arms
☐ Pins & Needles in Legs
☐ Ringing in Ears
☐ Sensitivity to Light
☐ Sinus Trouble
☐ Skin Conditions
☐ Sleeping Problems
☐ Stomach Upset
☐ Tension
☐ Ulcers
☐ Urinary Difficulty
☐ Other:
____

Lifestyle History

Please answer the following questions in regard to the 4 main pillars of health. Creating balance in these areas is critical to feeling great, improving your health, and preventing unwanted health issues.

Fitness

Are you happy with your current exercise routine/program? Yes No

What do you like to do for exercise? ____

How often do you exercise? Almost Never Less Than Once a Week Once a Week More Than Once a Week Almost every Day

Are you ready to improve you exercise routine? Yes No

Nutrition

Are you happy with your nutrition program? Yes No

Do you take any nutritional supplements? If Yes, What are you taking?____

How many glasses of water do you drink in an average day?____

Are you ready to improve your nutrition? Yes No

Stress

Do you have a daily stress release routine? Yes No

How often do you feel stressed? Never Once a Week More Than Once a Week Almost every Day Always

How would you rate your attitude? Negative 0 1 2 3 4 5 6 7 8 9 10 Positive

Would you like to feel less stress? Yes No

Overall, how would you rate your quality of sleep? Horrible 0 1 2 3 4 5 6 7 8 9 10 Great

Body

How would you rate your posture? Horrible 0 1 2 3 4 5 6 7 8 9 10 Great

Have you ever been involved in a car accident? Yes No

Would you like to improve your posture? Yes No

Your Goals

Which best describes <u>your</u> reason for consulting our office?

- ☐ I have a specific concern and require help only with this concern.
- ☐ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.
- ☐ I want to be healthier five years from now than I am today.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me (or my minor child-under 18) for further evaluation:

______________________________	______________________	______________________	__________
Signature	Print Name	Relationship to Patient if Minor	Date

Sensation Survey

As wellness chiropractors, we are interested in the function of your nervous system. 10% of your nervous system controls our sensations. By answering the following questions, we are able to see how this part of your nervous system is working. It also helps us monitor your progress. Please answer the following questions.

1. How frequently do you get headaches?

   a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week

2. On a scale of 1-10 how bad are they when they come?

   1 2 3 4 5 6 7 8 9 10

3. Do they negatively affect your life in any way? If yes, please explain.

____

4. How often do you have pain, stiffness or soreness in your neck?

   a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week

5. On a scale of 1-10 how bad is the discomfort?

   1 2 3 4 5 6 7 8 9 10

6. Do you ever get any numbness/tingle/pain in your arms/hands?

   a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week

7. Does the discomfort affect your life in any way?

____

8. How often do you have pain, stiffness or soreness in your mid to upper back?

   a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week

9. On a scale of 1-10 how bad is the discomfort?

   1 2 3 4 5 6 7 8 9 10

10. Do you ever get any numbness/tingle/pain in your ribs or chest?

    a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week

11. Does the discomfort affect your life in any way?

____

12. How often do you have pain, stiffness or soreness in your low back?

    a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week

13. On a scale of 1-10 how bad is the discomfort?

    1 2 3 4 5 6 7 8 9 10

14. Do you ever get any numbness/tingle/pain in your legs/feet?

    a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week

15. Does this discomfort affect your life in any way?

____

Twins Chiropractic

206 S. Placentia Ave. Placentia, CA 92870 Tel (714) 614-3195 Fax (714) 986-9600

Date: _____________

Patient: _________________________
Employer: _______________________
Claim Group: ____________________
SS#/ID#: _________________________

I hereby instruct and direct ____________________Insurance Company to pay by check made out and mailed to:

Twins Chiropractic
206 S. Placentia Ave.
Placentia, CA 92870

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Twins Chiropractic
206 S. Placentia Ave.
Placentia, CA 92870

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at _____________________ this_______________ day of_____________, 20_____________

____ **___________________________________**
Signature of Policyholder/Claimant **Witness**

X-RAY QUESTIONAIRE
For Women Only

Our consultation and examination may indicate that x-ray's are necessary to accurately diagnose and analyze your spinal condition. Should x-ray's be necessary we would like to confirm that you are not pregnant at this time.

NAME:_________________________________

_____ There is a possibility that I may be pregnant at this time.

_____ Yes, I am definitely pregnant.

_____ No, I am not pregnant at this time

_____ I request that x-rays films not be taken because ____
____
____

SIGNATURE____________________________ DATE____/____/____