Mission Viejo

Monday
Wednesday
Friday
10-1 and 3:30-6
Saturday - 10-11

Teitelbaum Chiropractic

Dr. Jan Teitelbaum

Advocate and Teacher of Healthy Lifestyle

Rancho Santa Margarita

Tuesday
Thursday
3:00-6

Welcome! We are glad you are here!

Today's Date
_____

First Name _____

Last Name _____

Gender M F

Marital Status: S M D W Partner

Birthdate _____

Height _____ Weight:_____

Number of children:

Ages of children:

Street Address_____

City _____ State _____ Zip Code_____

Home Phone (_____)_____

Cell Phone _(_____)_____

Work Phone (_____)_____

Email address

Whom can we thank for referring you?

_____

Please give your Insurance card to Sonia

Occupation _____Part Time/ Full Time

Please describe a typical work day

_____

_____

How can we help you?

_____

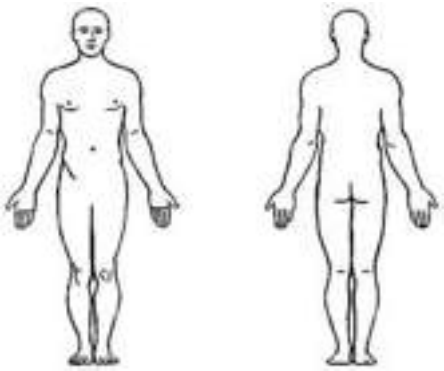
*Please describe your primary complaint*_____

_____

Explain the Pain

Dr. Jan's Notes

Please circle the areas affected, on the diagram below



What does it feel like?

- Numbness ☐
- Tingling ☐
- Stiffness ☐
- Dull ☐
- Aching ☐
- Cramping ☐
- Nagging ☐
- Sharp ☐
- Burning ☐
- Shooting ☐
- Throbbing ☐
- Stabbing ☐
- Swelling ☐
- Other_____

What makes it Better / Worse

	Better	Worse
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Lying down	☐	☐
Reading	☐	☐
Morning	☐	☐
Night	☐	☐
	☐	☐

What have you tried, to relieve your symptoms? Circle all that apply:
Prescription Medications, Over the Counter Drugs, Homeopathic Remedies, Physical Therapy Surgery, Acupuncture, Massage, Ice, Heat, Chiropractic, other? _____

Are you here as a result of an accident? Work ____ Auto____ Other _____

Activities of Daily Living

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of a car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for Family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery Shopping	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching Overhead	☐	☐	☐	☐
Showering or Bathing	☐	☐	☐	☐
Getting Dressed	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐
Getting to Sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Love Life	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐

Illnesses

- ☐ --Aids
- ☐ --Alcoholism
- ☐ --Arteriosclerosis
- ☐ --Cancer
- ☐ --Diabetes
- ☐ --Glaucoma
- ☐ --Gout
- ☐ --Heart Disease
- ☐ --Hepatitis
- ☐ --HIV
- ☐ --Measles
- ☐ --Multiple Sclerosis
- ☐ --Stroke

Operations

- ☐ ---Appendix
- ☐ ---Bypass surgery
- ☐ ---Cancer
- ☐ ---Cosmetic surgery
- ☐ ---Eye surgery
- ☐ ---Hysterectomy
- ☐ ---Pacemaker
- ☐ ---Tonsillectomy
- ☐ ---Vasectomy
- ☐ ---Spine surgery
- ☐ ---Other_____

Injuries

- ☐ -had a Broken bone
- ☐ -had a Spine Disorder
- ☐ -had a Nerve Disorder
- ☐ -been knocked unconscious
- ☐ -been injured in an accident
- ☐ -used a cane or crutches
- ☐ -used a neck or back brace

Allergies

Do you have Allergies?

Yes No

List Allergies

_____

_____

_____

_____

Treatments

- ☐ Acupuncture
- ☐ Antibiotics
- ☐ Birth control Chemotherapy
- ☐ Chiropractic
- ☐ Dialysis
- ☐ Herbs
- ☐ Homeopathy
- ☐ Hormone replacement
- ☐ Physical therapy
- ☐ Inhaler
- ☐ Allergy Shots
- ☐ Nutritional Supplements
- ☐ Medications: Prescript
- ☐

Other Health Concerns

Please check the box next to any condition that you currently have or <u>have had.</u>

Dr. Jan's Notes

Musculoskeletal

Osteoporosis----
Knee injuries----
Arthritis----------
Foot/ankle pain
Scoliosis----------
Shoulder issues
Neck Pain--------
Elbow/wrist pain
Back Problems--
TMJ Issues------
Hip disorders----
Poor posture-----

Digestive

Anorexia-----
Bulimia------
Ulcer---------
Food Sensitivities
Heartburn--
Constipation
Diarrhea-----

Neurological

Anxiety----------
Depression-----
Headaches-----
Migraines-------
Dizziness-------
Pins and Needles---------
Numbness-----

Respiratory

Asthma----------
Apnea----------
Emphysema---
Shortness of Breath----------
Pneumonia-----

Cardiovascular

High Blood Pressure----------
Low Blood Pressure----------
High Cholestero
Poor Circulation

Other

Thyroid----------
Immune Disorders--
Ringing in Ears------
Bedwetting----------
Prostate Issues------
Poor Appetite---------
Sudden Weight Gain

Are there any major illnesses in your family history?_____

Health and Nutrition Habits and Goals

	#per day	# per week
Alcohol Use	_____	_____
Coffee Use	_____	_____
Soda Use	_____	_____
Tobacco Use	_____	_____
Fast Food	_____	_____

Pain Relievers Y N
Prescription Pills Y N
OTC Pills Y N
_____

Stress Levels
High Ave Low

Hours of Sleep per night? _____

Water Intake /
8oz glasses per day? _____

Have you ever suffered a fall or other serious injury? Y N What age?_____

Describe_____

How do you care for yourself ?

	Poor	Fair	Pretty good	Excellent
Physical	☐	☐	☐	☐
Nutritional	☐	☐	☐	☐
Emotionally	☐	☐	☐	☐
Prayer or meditation	☐	☐	☐	☐
Financial Peace	☐	☐	☐	☐

List your Hobbies:
_____
_____
_____
_____

* I realize that an X ray might be hazardous to an unborn child and to the best of my knowledge I am not pregnant.
* I grant permission for you to call, text, or email to verify appointments or share health information as an extension of my care.
* The information I have provided is complete and truthful. I have not misrepresented my current condition in any way.
*

If the patient is a minor, please print the child's name:_____

_____ _____
Signature Date

Consent to Initiate Care

At our office, we have one simple goal. We want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some business procedures in this clinic to keep our fees reduced. Please read over these procedures below to understand how our clinic functions, and to decide if you wish to participate. If you have any questions please direct them to the receptionist.

1. Patients may choose to be cared for by any available staff doctors present on any given visit.
2. You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by our office. Our Office takes *no responsibility* for non-payment by insurance companies for services rendered at our clinic.
3. _____(practice name) will not respond to *any* requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records and the original x-rays at any time they request.
4. No balances can be kept or run by patients at any time.
5. All adjustment visits are paid immediately ***prior*** to the service being rendered.
6. All examinations and x-rays are paid upon completion of these services.
7. Our clinic reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

To initiate care at our facility, there are two required visits you will be scheduled for. If you cannot attend either of these two visits, the negative impact on your care will be profound, and we cannot in good conscious initiate your care. These required visits are:

1. **Initial Interview and Examination:** *This visit will consist of a health history, chiropractic examination, and x-rays if needed. (This is probably the visit you are present for now) Total time about 30 – 45 minutes.*
2. **Report of Findings:** *This visit will consist of a detailed report of findings with recommendations for your care. Also included is information on chiropractic health and wellness. Recommendations on what to do between visits and a detailed explanation of your care plan. X-rays will also be reviewed at this time. We recommend that spouses and adult family members attend this visit with the patient. Children should not attend this visit as the material may be too advanced and children will find it difficult to stay attentive without becoming a distraction for that amount of time. Due to the time required, there are only certain times this visit is given. Check with our receptionist or one of our doctors for available times. Total visit time about 60 -75 minutes.*

I wish to initiate care at _____(practice name). I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print your name _____ **Today's Date** _____

Sign your name _____