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?

____

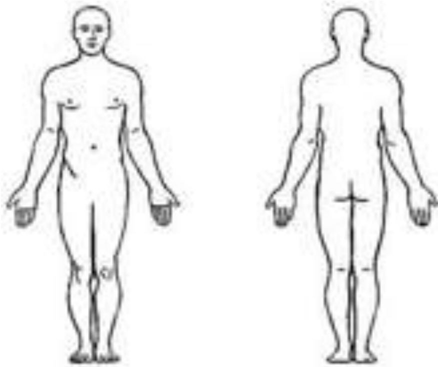
*Please describe your primary complaint*____

____

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

Dr. Jan's Notes

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

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------ ☐

Cardiovascular

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

Respiratory

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

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

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ______________________ Signature: ____________________ Date:

Parent or Guardian: __________________ Signature: ____________________ Date:

Witness Name: _____________________ Signature: ____________________ Date: