

Los Gatos Chiropractic and Wellness Center

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone# Home: (____) _____ Other: (____) _____

Occupation: _____

Date of Birth: _____ Age: _____ Sex: Male/Female (please circle)

Marital Status: S M W D (Please Circle)

Name and Number of Person to Contact in Case of Emergency:

Referred By:

May we e-mail you with information about our office? Yes No e-mail address _____

When, where and from whom did you last receive medical or health care? _____

What are your most important health concerns? Please list from most to least important.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Others: _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU ARE INTERESTED IN:

Food Allergy Testing

Hormone Testing

Heavy Metal Testing

Nutritional Testing

Fertility Testing

Wellness Screening

Testing For Depression

Complete Cardiovascular Panel

Gynecologic & Breast Exam

Anxiety or Mental Health

Anti-aging/preventive medicine testing

Digestive Analysis

Detoxification Diet

Non-hormone Options for Birth control

Body Composition Analysis

Health Report:

Reasons for seeking Care: _____

List any other providers seen for this: _____

List any diagnosis made and treatment received: _____

Have you had something similar to this before: _____

List the name of any family member with a similar problem: _____

Have you ever received chiropractic treatment previously? ____ Yes ____ No

If yes, explain: _____

Have you been treated for any health conditions in the last year:

Are you currently taking medications? ____ Yes ____ No List Medications: _____

What medications have you taken in the past, if any: _____

List the conditions you are taking medications for: _____

Please list reasons and dates of any surgeries or hospitalizations _____

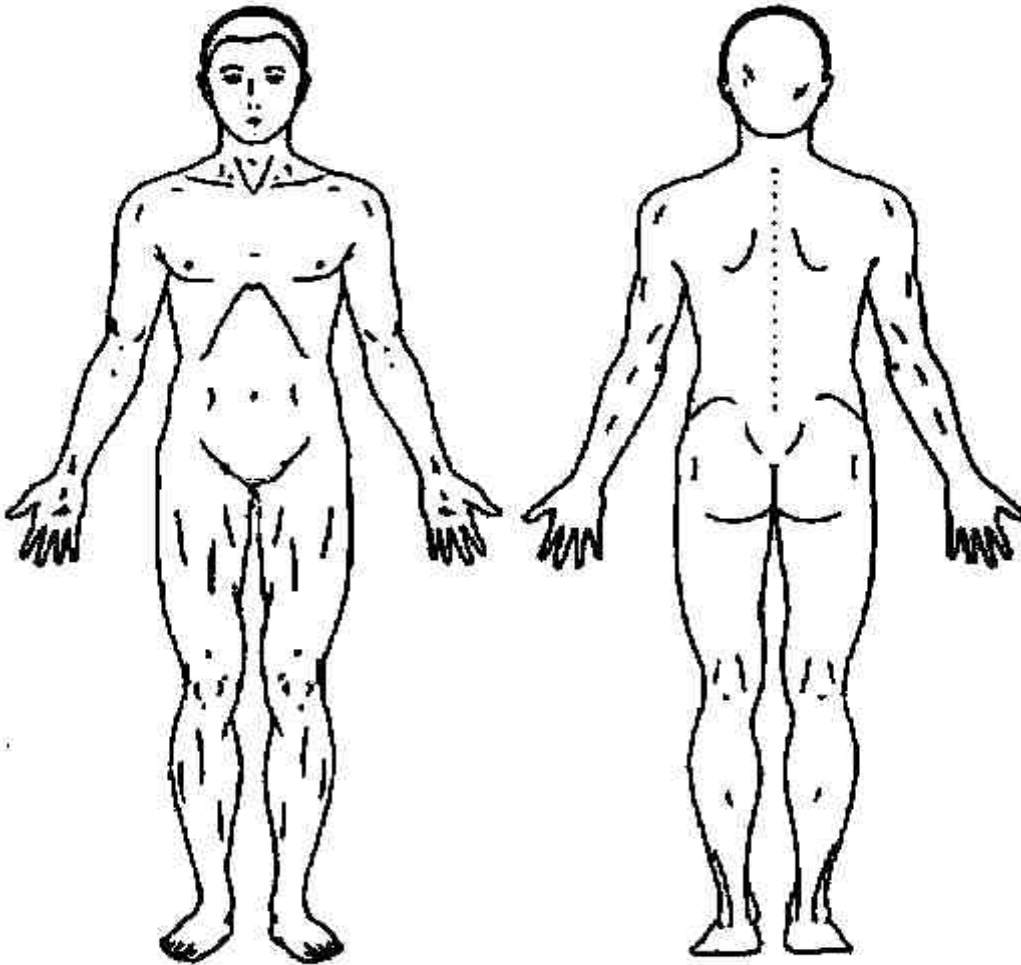
Any previous broken bones or sprains/strains: _____

Family history of health conditions like: cancer, diabetes, arthritis, heart disease, stroke, or epilepsy:

Do you smoke Y/N. Alcohol Y/N, If yes how much: _____

Caffeinated drinks per day: _____ Do you take any vitamins or Supplements? If yes, the type and how often: _____

Please indicate area of complaint on the picture.



Describe symptoms _____

What activities aggravate your condition: _____

What activities lessen your condition: _____

Is the condition worse at certain times? Y/N. When? _____

Is the condition interfering with:

Work Sleep Daily Life

Is the condition getting worse or better? _____

Is the condition due to injury at: Work Auto Accident Personal Lifestyle Activities

Please check Y for Yes N for No and P for Past for any of the following health conditions:

GENERAL INFORMATION:	Y	N	P	EYES:	Y	N	P
Recent Weight Gain/Loss				Wear Eye Glasses/Contacts			
Weakness				Double Vision			
Fatigue				Blurred Vision			
Fever				Loss of Vision			
Fainting				Eyes Sensitive to Light			
Nausea				Excessive Tearing			
Vomiting				Dry Eyes			
Balance Problems				EARS:	Y	N	P
Jaw Pain (TMJ)				Loss of Hearing			
Neck Pain				ringing/Buzzing in Ears (Tinnitus)			
Neck Stiffness				Ear Infections			
Shoulder Pain				Vertigo (Dizziness)			
Arm Pain				Any Discharge from Ears			
Wrist/Hand Pain				NOSE:	Y	N	P
Numbness Arms or Hands				Sinus Problems			
Upper Back Pain				Nosebleeds			
Lower Back Pain				Loss of Smell			
Hip Pain				Any Discharge from Nose			
Leg Pain				MOUTH/THROAT:	Y	N	P
Knee Pain				Tooth Pain			
Ankle/Foot Pain				Sores in Mouth, Lips or Gums			
Numbness Legs or Feet				Frequent Sore Throats			
Joint Swelling				Difficulty Swallowing			
Tension				Mercury Fillings			
Nervousness				RESPIRATORY (LUNGS):	Y	N	P
Anxiety				Difficulty Breathing			
Irritability				Chronic Cough			
Sleeping problems/Insomnia				Asthma			
Depression				Bronchitis			
Liver Problems				Emphysema			
Cancer				Tuberculosis or Pneumonia			
Metal Implants				Last Chest Radiograph			
Headaches				CARDIO (HEART PROBLEMS):	Y	N	P
Loss of Consciousness				Chest Pain			
Dizziness				Difficulty Breathing			
Memory Problems				Palpitations			
Seizures/Convulsions				Night Sweats			
				Cold Extremities			
				High Blood Pressure			
				Low Blood Pressure			
				Heart Murmur			
				Ever Have an ECG/EKG			

Please check Y for Yes N for No and P for Past for any of the following health conditions:

GI (GASTROINTESTINAL):	Y	N	P	GU (GENITOURINARY):			
Upset Stomach				FEMALES:	Y	N	P
Loss of Appetite				Pelvic Inflammatory Disease			
Indigestion				Urinary Tract Infections			
Constipation				Breast Cancer &/or Benign Tumors			
Diarrhea				Blood in Urine			
Bloody Stool				Painful Urination			
Abdominal Pain				Vaginal Discharge or Chronic Yeast			
Excessive Gas				Fibroids			
Loss of Bowel Control				Breast Tenderness			
Hemorrhoids				Hot Flashes			
Have You Had A Colonoscopy				Loss of Bladder Control			
ENDOCRINE:	Y	N	P	Currently Pregnant			
Cold or Heat Intolerance				Have you had a Pelvic Ultrasound			
Excessive Sweating				Have You Had A Mammogram			
Excessive Thirst or Hunger				MALES:	Y	N	P
Diabetes				Prostate Problems			
Thyroid Conditions				Hernias			
Kidney Conditions				Penile Discharge			
OTHER:	Y	N	P	Blood in Urine			
Currently Sexually Active				Painful Urination			
Currently Trying to Become Pregnant				Frequent Urination			
				Testicular Pain			
				Loss of Bladder Control			

The above information is true to the best of my knowledge.

Patient's Signature:

X _____ Date _____

Informed Consent & Office Policies

Our commitment here at the Los Gatos Chiropractic and Wellness Center is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interest it may be necessary to share information with other Health care Providers or Associates for the purpose of ordering laboratory analysis, payment, scheduling of your appointment or in the instance of a second opinion. If any other uses or disclosures other than the ones listed above are needed, information will be released with the written authorization of the individual, as provided for by law.

Please be aware Health and Safety Code section 109250 et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation or cure of cancer. If you have been diagnosed with cancer we will be unable to treat you for this diagnosis.

We do not accept insurance. We ask that you know your insurance coverage prior to visiting us. All payment is expected at the time of service. Debit cards, master card, visa, cash and check are acceptable forms of payment.

Please be advised that if you cannot keep your scheduled procedure or appointment for any reason, we request that you cancel the appointment with at least 24 hours prior. Failure to cancel within that time frame or no showing for the appointment will cost a fee of \$50.

Thank you for your cooperation. We look forward to assisting you on your path to wellness.

Sincerely,

Los Gatos Chiropractic and Wellness Center

I have read and understand this form.

Signed: _____

Print Name: _____ Date: _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic names below and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

<p>_____</p> <p>To be completed by the patient:</p> <p>_____</p> <p>Print Patient's Name</p> <p>_____</p> <p>Signature of Patient</p> <p>_____</p> <p>Date Signed:</p>	<p>_____</p> <p>To be completed by patient's representative, if necessary, e.g. if patient is a minor or physically or legally incapacitate.</p> <p>_____</p> <p>Print Name of Patient</p> <p>_____</p> <p>Print Name of Patients Representative</p> <p>_____</p> <p>Signature of Patients Representative</p> <p>As: _____</p> <p>Relationship or Authority of Patients Representative</p> <p>_____</p> <p>Date Signed</p>
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Name of Doctor treating this patient: **Dr. Kate Fox and/or Dr. Jenny Walker**