Welcome to Desert Cities Chiropractic Date:_____

Name:_____ DOB:_____ Age:_____ Primary Language:_____

Address:_____Apt#____ City:_____State:____Zip:_____

Cell Phone:_____ HomePhone:_____ Social Sec.#:_____-_____-_____

Email address:_____

Status:☐Single, ☐Married, ☐Divorced, ☐Widowed Sex: ☐M ☐F ☐Declined to state Sex at birth: ☐M ☐F ☐Declined to state

Your Employer:_____ Address:_____ Occupation:_____

In case of an emergency please notify:_____Phone:_____

Please Let Us Know Who Referred You- ☐Facebook ☐Groupon ☐Yelp ☐Website ☐Google ☐Phone Book ☐ Insurance ☐ Midwife ☐Ob/Gyn ☐Friend/ Family ☐Current Patient ☐Doctor ☐Attorney ☐Postcard ☐Other_____

INSURANCE INFORMATION

Name of Insured:_____ID #:_____

Relationship to Patient:_____ DOB:_____

Insurance Company:_____ Phone #_____ Group #:_____

INSURANCE ASSIGNMENT & RELEASE OF LIABILITY

I, the undersigned, certify that I, and/or my dependent(s), have insurance coverage with _____Insurance and assign directly to Angelopoulos Chiropractic Prof. Corp./Dr. Angelopoulos all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future. X_____

INITIAL

CONSENT TO CHIROPRACTIC ADJUSTMENTS AND TREATMENT

I understand that Desert Cities Chiropractic is a division of Angelopoulos Chiropractic Prof. Corp. and is owned and operated by Dr. Athanasia Angelopoulos and Dr. Christopher Angelopoulos. I acknowledge that during the course of my care I (or the person named below for whom I am legally responsible) may receive chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, massage and diagnostic x-rays by Dr. Athanasia Angelopoulos and/or Dr. Christopher Angelopoulos. I understand that, as the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments the most common risks are temporary aggravation of my condition/soreness or bruising. Rarer risks include, but are not limited to, fractures, strokes, dislocation, sprains, burns and aggravation of disc injuries. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him or her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests. I have read, or have read to me, the above consent. 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. X_____

INITIAL

NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices that was provided to me. I understand that I have the right to a paper copy of this policy at any time upon request. If I have any questions, I may contact Dr. Athanasia Angelopoulos at 760-952-3300. X_____

INITIAL

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

CONSENT TO TREATMENT OF MINOR

I hereby authorize Dr. Athanasia Angelopoulos D.C. and/or Dr. Christopher Angelopoulos, D.C. to administer treatment as they deem necessary to my son/ daughter.

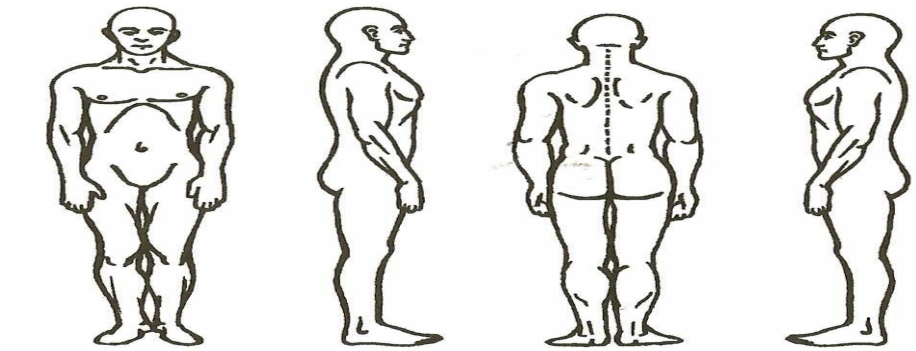
X_____ _____

Signature of Parent, Guardian or Personal Representative Date

On the figures to the right, please indicate where you have symptoms.
Use the following key:

PAIN = XXX

NUMBNESS or TINGLING =!!!



How long have you had your symptoms?_____

If you have had symptoms in this area before, when did it first occur?_____

What caused this pain to begin:_____

BACK PAIN: If you have back pain please describe:

Circle the severity of your BACK pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating pain)

What percentage of the time do you experience this problem? ☐<25% ☐25% ☐50% ☐75% ☐100%

My BACK symptoms are: ☐Getting Worse ☐Getting Better ☐Up & Down ☐Not Changing

Describe BACK symptoms: (OK to check more than one) ☐Dull/ Ache ☐Soreness ☐Pressure ☐Tightness
☐Throbbing ☐Burning ☐Spasms ☐Sharp/Stabbing ☐Numbness ☐Tingling ☐Weakness
☐Other:_____

BACK pain made worse by: (OK to check more than one) ☐Sitting ☐Standing ☐Walking ☐Bending
☐Lifting ☐Sleeping ☐Twisting/Turning ☐Physical Activity ☐Not changing
BACK pain relieved by:_____

NECK PAIN: If you have neck pain please describe:

Circle the severity of your NECK pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating pain)

What percentage of the time do you experience this problem? ☐<25% ☐25% ☐50% ☐75% ☐100%

My NECK symptoms are: ☐Getting Worse ☐Getting Better ☐Up & Down ☐Not Changing

Describe NECK symptoms: (OK to check more than one) ☐Dull/ Ache ☐Soreness ☐Pressure ☐Tightness
☐Throbbing ☐Burning ☐Spasms ☐Sharp/Stabbing ☐Numbness ☐Tingling ☐Weakness
☐Other:_____

NECK pain made worse by: (OK to check more than one) ☐Sitting ☐Standing ☐Walking ☐Bending
☐Lifting ☐Sleeping ☐Twisting/Turning ☐Physical Activity ☐Not changing
NECK pain relieved by:_____

HEADACHES: If you have headaches please describe:

Circle the severity of your HEADACHE pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating pain)

How many times per month are you experiencing HEADACHES?_____x per month

My HEADACHES symptoms are: ☐Getting Worse ☐Getting Better ☐Up & Down ☐Not Changing

Describe HEADACHES symptoms: (OK to check more than one) ☐Dull/ Ache ☐Soreness ☐Pressure
☐Tightness ☐Throbbing ☐Burning ☐Spasms ☐Sharp/Stabbing ☐Numbness ☐Tingling
☐Weakness ☐Other:_____

HEADACHES made worse by: (OK to check more than one) ☐Sitting ☐Standing ☐Walking ☐Bending
☐Lifting ☐Sleeping ☐Twisting/Turning ☐Physical Activity ☐Not changing
HEADACHES relieved by:_____

Name:_____ DOB:_____

Have you had X-Rays / MRI / CT Scan of the problem area within the last 12 months? ☐ Yes ☐ No

Name of other doctors who have treated you for this condition:_____

What treatment have you already received for this condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care

Is this condition due to an accident? ☐ Yes ☐ No

If Yes, please provide: Date of accident:_____ Type of Accident: ☐ Auto ☐ Work ☐ Other

* Please check the box if you have ever had/ have the condition.

General:

☐ Alcoholism
☐ Anemia
☐ Cancer
☐ High cholesterol
☐ Diabetes
☐ Thyroid
☐ Gout
☐ Rheumatic fever
☐ Catch colds easily
☐ Hypoglycemia
☐ Rheumatoid arthritis
☐ Multiple sclerosis
☐ Depression
☐ Frequent influenza
☐ Osteoarthritis
☐ Tuberculosis
☐ HIV positive
☐ Parkinson's disease
☐ Ulcers
☐ Hepatitis- type/s_____
☐ Epilepsy/Seizures
☐ Pneumonia
☐ Venereal Disease
☐ Polio
☐ Skin Problems

Gastrointestinal:

☐ Gall bladder problem
☐ Heartburn
☐ Mucus in stool
☐ Liver trouble/Hepatitis
☐ Nausea
☐ Colitis
☐ Excessive thirst
☐ Diarrhea
☐ Hiatal hernia
☐ Distress from greasy food
☐ Blood in stool
☐ Vomiting
☐ Metallic taste in mouth
☐ Constipation
☐ Burning in stomach relieved by eating
☐ Recent weight gain/ loss

Cardiovascular:

☐ Pain over heart
☐ Irregular heartbeat
☐ Low blood pressure
☐ Heart attack
☐ Stroke
☐ High blood pressure
☐ Swelling in ankles
☐ Shortness of breath on exertion
☐ Pressure over chest

Nervous System:

☐ Dizziness/Lightheaded
☐ Fainting
☐ Discoordination
☐ Memory loss

Eye, Ear, Nose and Throat:

☐ Vision problems
☐ Hearing loss
☐ Ear pain
☐ Ear noises
☐ Nose bleeds
☐ Frequent sinus trouble
☐ Difficulty breathing through nose
☐ Difficult speech
☐ Dental problems
☐ Hoarseness
☐ Sore throat

Urinary Tract:

☐ Blood in urine
☐ Inability to control urination
☐ Painful urination
☐ Bladder infection
☐ Kidney stones

Respiratory:

☐ Chest pain
☐ Chronic cough
☐ Coughing up blood
☐ Spitting up phlegm
☐ Difficulty breathing
☐ Emphysema
☐ Shortness of breath
☐ Asthma
☐ Allergies

Women Only:

☐ Irregular periods
☐ Headaches with period
☐ Premenstrual depression
☐ Hot flashes
☐ Menstrual cramps
☐ Painful breasts
☐ Vaginal discharge
☐ Excessive flow
☐ Lumps in breasts
☐ Menopausal symptoms
☐ Hysterectomy

Are you Pregnant? ☐Yes ☐No

Men Only:

☐ Burning on urination
☐ Need to get up at night to urinate
☐ Prostate trouble
☐ Difficulty starting urine
☐ Feeling of incomplete bowel evacuation
☐ Dripping after urination

Blood Sugar:

☐ Irritable before meals
☐ Heart palpitates w/skipped meals
☐ Get "shaky" if hungry
☐ "Lightheaded" if meals delayed
☐ Fatigue relieved by eating
☐ Abnormal craving for sweets/snacks

FAMILY HISTORY:

☐ Cancer
☐ Heart Problems
☐ Stroke
☐ Diabetes
☐ Rheumatoid Arthritis
☐ High Blood Pressure

Do you have a Pacemaker? ☐Yes ☐No

Do you have a Defibrillator? ☐Yes ☐No

List All Surgeries and Dates:_____

_____

_____

_____

_____

_____

List All Medications/Dosages:_____

_____

_____

_____

_____

_____

_____

List All Allergies:_____

_____

_____

Daily Living Impact- Please describe how you have been impacted by your symptoms.

Work:

What is your primary function at work?_____

Do you ever need to ask for help? Yes No

Are there any parts of your job you find yourself shying away from?_____

Have you ever had to miss work? Yes No How many days?_____

Household Chores/ Yard Work:

Are there any chores you are now avoiding/ shying away from? Yes No

If yes, please list:_____

Do you have to take more breaks to complete your chores? Yes No

Have you had to ask family members/ friends to assist with chores? Yes No

Have you considered hiring a person to do chores for you? Yes No

Recreational Activities/ Exercise:

What recreational activities/ exercise are you involved in?_____

Are there any activities you find yourself shying away from? Yes No If yes, please list_____

Relationships:

What activities or things do you usually do with your Spouse, Children/ Friends?_____

_____

Have you been avoiding going out with friends or family because of your pain? Yes No

Do you find yourself avoiding playing with/ holding children or grandchildren? Yes No

Do you think your spouse or family might say you have been less patient than usual? Yes No

Are there any other areas of your life affected by this condition? Yes No If yes, please list_____

_____

Phase 1: Relief Care

If you are in pain when you come into our Chiropractic office, the first objective is to help you feel better. Depending on the severity of your problem, and your current health status, it is typical to need care 2-3 times per week for several weeks.

Phase 2: Corrective/Restorative Care

During the corrective care phase, muscles and other tissues are able to heal more completely, thereby helping to establish more functional postural and movement patterns. This is essential in preventing re-injury. It is common to need care 1 to 4 visits per month for 6-12 months, depending on your overall health, consistency with home exercises and the severity of the original condition.

Phase 3: Wellness Care

Once your body has fully healed, it is important to come in for periodic adjustments to avoid problems in the future. Usually, this only requires a periodic visit to the Chiropractor based on your lifestyle and goals.

What Is Your Goal For Your Care? Indicate **<u>one</u>** of the following statements that apply to you:

☐ I have a specific health concern. (***I want short term relief only without a corrective or wellness program***)

☐ I want to ensure that my health concerns do not become an ongoing problem. (***I want relief and to maintain a pain free state of health***)