LA CHIROPRACTIC CLINIC

8711 Venice Blvd, Suite A. • Los Angeles, CA 90034 • P: (562) 262-2225 • F: (424) 204-0425 • E: Tyler@sanpedrocc.com

1. Patient Personal Information DATE:__________

Last Name: ____________ First Name: ____________ MI: ______

Date of Birth: ____/____/____ Age: ____ Social Security # ______-______-______

Sex: ❒Male ❒Female Marital Status: ❒Married ❒Divorced ❒Single ❒Widowed

Height: ______ Weight: ______

Address: ____________ City: ____________ State: ____ Zip Code: ______

Home phone: ____________ Mobile phone: ____________

Work phone: ____________ E-mail address: ____________

Medical History:

Do you have, or have you ever had, any of the following conditions (circle any that apply):

Allergy Shots	Anorexia	Arthritis	Breast Lump	Bulimia	Cataract
High blood pressure	Heart Disease	Heart attack	Cancer	Herpes	Polio
Thyroid Disease	Seizures / Epilepsy	Stroke	Diabetes	Goiter	Mumps
Bleeding Disorder	Hernia	Appendicitis	Bronchitis	Tumors	Gout
Chicken Pox	Fractures	Blood clots	Alzheimer's	Tuberculosis	Ulcers
High Cholesterol	Alcoholism	Hepatitis	Aids/Hiv	Emphysema	Asthma
Chemical Dependency	Multiple Sclerosis	Pancreatitis	Glaucoma	Osteoarthritis	Anemia
Rheumatoid Arthritis	Kidney Problems	Liver problems			

❒ Smoke, Packs /Day ____ ❒ Alcohol, Drinks / Week ____ ❒ Coffee/Caffeine, Cups/Day ____

Are you pregnant? ❒ **Yes** ❒ **No** Have you ever had any surgeries? ❒ **Yes** ❒ **No**

If "**yes**", please list each surgery with year received:

____

Family Medical History (examples: Diabetes, High Blood Pressure, Cancer, etc.)

Mother: ____________ Father: ____________

Siblings/Other Relatives: ____________

Have you **ever** been involved in a previous ❒ Car accident ❒ WC Accident ❒ Other: ______

If "***yes***", how many: ____ When: ______

Do you have a complete recovery from those accidents: ❒ **Yes** ❒ **No**

If "**no**" what are the residual complaints? ____________

Do you have any allergies to medications: ❒ **Yes** ❒ **No** If "**yes**" please list: ____________

Are you allergic to ❒ Latex ❒ Medical Tapes?

Please list **ALL** medications (prescribed and over-the-counter) that you **CURRENTLY** take:

____

____

Do you exercise: ❒ None ❒ Moderate ❒ Daily ❒ Heavy

Work Activity: ❒ Sitting ❒ Standing ❒ Light Labor ❒ Heavy Labor

2. Emergency Contact Information

In the unlikely event of an emergency during your treatment in our facility, who should we contact?

Name: ______________________________ Relation to you: ____________________

Phone Number: ________________________

3. Accident / Injury Questionnaire

Date of accident: ______________________ Time of accident: _____:_______ am / pm

Type of accident: ☐ Automobile Accident ☐ Worker's Compensation Accident/Injury

☐ Slip/Fall Accident ☐ Pedestrian Accident

☐ Other Accident: ____________________ ☐ Other Injury: __________________

Location of Accident (street/cross streets): ____

If pedestrian were you: ☐Crossing a street ☐On sidewalk ☐Walking/riding in the street ☐Other: ___________

Were you thrown to the ground: ☐Yes ☐No Speed of the other vehicle at impact: ________________

If Auto Collision: What part of your car was hit?

☐Back end ☐Back end passenger side ☐Back end driver side ☐Front end

☐Front end passenger side ☐Front end driver side

Side impact ☐Side front ☐Side middle ☐Side rear

Where were you in the car?

☐The driver of the car ☐Passenger in a car

If passenger were you in: ☐Front seat ☐Back seat right ☐Back seat middle

☐Back seat left ☐Third row seat right ☐Third row seat middle ☐Third row seat left

Was your head turned upon impact? ☐Yes ☐No ☐Other: ____________________

Were you leaning forward at the time of impact? ☐Yes ☐No ☐Other: ____________________

Was your body turned at the time of impact? ☐Yes ☐No ☐Other: ____________________

Did you brace for the accident? ☐Yes ☐No ☐Other: ____________________

Were you wearing your seatbelt? ☐Yes ☐No ☐Other: ____________________

Did the airbag deploy? ☐Yes ☐No ☐Other: ____________________

Did you hit your head? ☐Yes ☐No ☐Other: ____________________

Describe in your own words what happened: ____

____

____

____

4. Immediately After accident / Injury

Did you lose consciousness? ☐Yes ☐No ☐Unknown

How did you feel (check all that apply):

☐Confused ☐Dazed ☐Dizzy ☐Nervous ☐Other: ___________

Where did you immediately develop PAIN (O) or have lacerations/CUTS (☐) (check all that apply):

O ☐ Head O ☐ Neck O ☐ Upper/Mid Back O ☐ Lower back O ☐ Pelvis O ☐ Abdomen O ☐ Shoulders

O ☐ Chest/Rib Cage O ☐ Arms O ☐ Elbow O ☐ Forearms O ☐ Wrists O ☐ Hands O ☐ Buttocks

O ☐ Hips O ☐ Thighs O ☐ Knees O ☐ Legs O ☐ Ankles O ☐ Feet O ☐ Other: ____________________

Did police come to the scene? ☐Yes ☐No Do you have police report? ☐Yes ☐No

Did you receive emergency care at the accident/injury site? ☐ No ☐ Yes -- (please check all that apply):

☐ Bandages ☐ Splints ☐ Brace ☐ Neck Collar ☐ Other: ____________

After the accident/injury, where did you go?

☐ Hospital ☐ Home ☐ School ☐ Work ☐ Other: ____________

By whom were you driven?

☐ Myself ☐ Friend ☐ Family ☐ Ambulance ☐ Other: ____________

5. Hospital Visit After Accident / Injury (If you did not go to hospital skip to section 6)

When did you go to the hospital? ☐ Immediately ☐ Later That Day ☐ Next Day

☐ Days Later ☐ Other: ________________ ☐ Never

Hospital name: ______________________________________ Examined by doctor: ________________

☐ X-rays ☐ Cat Scan ☐ MRI were taken of what body part/s:

☐ Head ☐ Neck ☐Upper/Mid Back ☐ Lower Back ☐ Pelvis

☐ Abdomen ☐ Shoulders ☐ Chest/Rib Cage ☐Arms ☐ Elbows

☐ Forearms ☐ Wrists ☐ Hands ☐ Buttocks ☐ Hips

☐ Thighs ☐ Knees ☐ Legs ☐ Ankles ☐ Feet

☐ Other: ________________ ☐ **No x-rays taken** ☐ **No Cat Scan taken** ☐ **No MRI taken**

What was the diagnosis given at the hospital (describe location on body):

☐ Concussion ☐ Whiplash ☐ Disc Injury ☐ Dislocation ☐ Fracture

☐ Sprain ☐ Strain ☐ Laceration ☐ Contusions ☐ Other: ________________

What treatment was administered at the hospital?

☐ Oral Medication ☐ Sutures ☐ Splint ☐ Collar ☐ Injection ☐ Ice Pack

☐ Cast ☐ support ☐ Brace ☐ Surgery ☐ Hot Packs ☐ Bandages ☐ Antiseptics

☐Other: __________________________ ☐ **No Treatment**

Upon discharge, whom were you told to see?

☐ General Practitioner ☐ Chiropractor ☐ Neurologist ☐ Physical Therapist ☐ Orthopedist

☐ Internist ☐ General Surgeon ☐ Plastic Surgeon ☐ Other: ________________________ ☐ **No one**

Upon discharge, what recommendations were made?

☐ Rest ☐Ice ☐Heat ☐ Collar ☐ Support ☐ Time off work

☐ Other: ________________________ ☐ No further care ☐ **No recommendations**

Upon discharge, what medications were prescribed? ☐ Pain ☐ Anti-inflammatory

☐ Antibiotics ☐ Nervousness ☐ **No medications**

6. Following the Accident / Injury

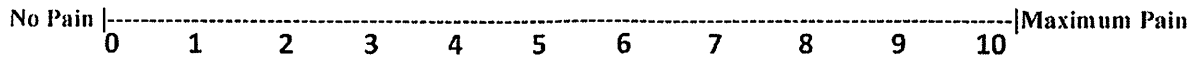
How much later did additional symptoms develop?

☐ Immediately ☐ Hours ☐ That Evening ☐ Next Morning ☐ Days ☐ Weeks

☐ Month ☐ Other: ______________________ ☐ **No other symptoms**

What additional symptoms developed?

Please indicate with a mark on this line, the level of pain you are now experiencing:

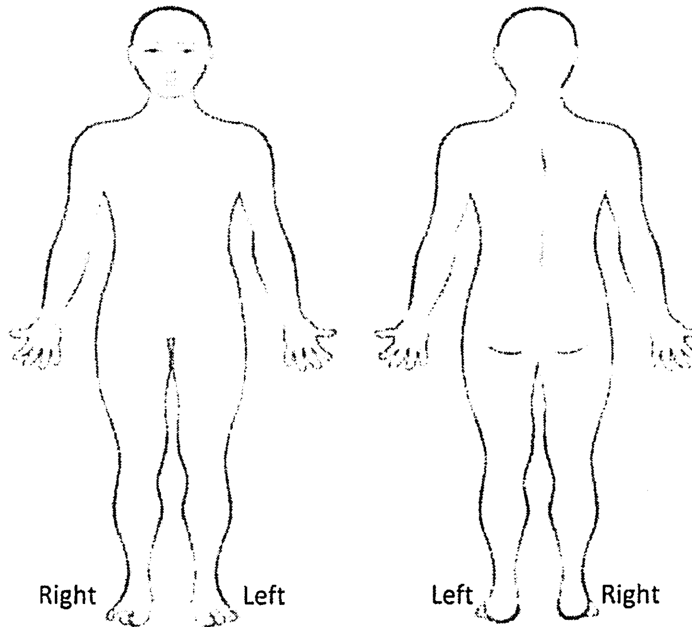


Listed below are 5 types of pain. Select the type (or Types) of pain patient is experiencing.

Mark the body figures below to indicate where on the body the pain is being felt. Be sure to use the corresponding symbols for each type of pain. Please include the time spent per area.

Numbness	Stabbing	Ache
XXXXX XXXXXXXX XXXXX	SSSSS SSSSSSSSS SSSSS	/////// ///////////// ///////

Pins and Needles	Burning
OOOOO OOOOOOOOOO OOOOO	+++++ ++++++++++++ +++++



Since your accident/injury, have you suffered from:

☐Blurred Vision	☐Double	☐Vision Trouble	☐Hearing Trouble
☐Ear Ringing	☐Chest Pain	☐Breathing Trouble	☐Palpitations
☐Constipation	☐Diarrhea	☐Nausea	☐Vomiting
☐Frequent Urination	☐Painful Urination	☐Incontinence	☐Anxiety
☐Depression	☐Mood Swings	☐Nervousness	☐Poor Memory
☐Tension	☐Convulsion	☐Dizziness	☐Headaches
☐Fainting	☐Loss of Balance	☐Fatigue	☐Restlessness
☐Insomnia	☐Light Sensitivity	☐Reduced Appetite	☐Weakness
☐Weight Gain	☐Weight Loss	☐Other:	☐**No additional symptoms**

What makes your pain better?

☐Rest ☐Medications ☐Heat ☐Ice ☐Stretching ☐Lying down

☐Other: ______________________________

What makes your pain worse?

☐Sitting ☐Standing ☐Bending ☐Lifting ☐Walking ☐Lying Down

☐Other: ______________________________

Are you restricted in any of the following areas as a result of this accident / injury?

☐Daily Living ☐Work/Occupational ☐Recreational Activities

☐Other: ______________ **☐No restrictions**

Have you missed work due to this accident / injury?

☐Missed no work ☐Limited work activity ☐Missed work from: ________ to ________

Did you self-treat your symptoms?

☐Ice ☐Heat ☐Bed rest ☐OTC Medication

☐Other: ______________ **☐Did not self-treat**

Did you seek health care elsewhere?

☐General Practitioner ☐Internist ☐Chiropractor ☐Neurologist

☐Orthopedist ☐General Surgeon ☐Plastic Surgeon ☐Psychologist

☐Other: ______________ **☐Did not seek other health care**

Name/s of doctor/s: ______________________________

____

Diagnosis, treatment and recommendations: ______________________________

____

____

Have you had any of the following tests?

☐CT Scan ☐MRI ☐EMG ☐Other: __________ ☐No tests

What is the reason for seeking today's consultation?

☐Persisting Complaints ☐Worsening of Symptoms ☐Other: __________

Have you contacted an insurance adjuster or representative regarding this claim?

☐No ☐Yes—Company: ______________ Claim#: ______________

Adjuster: ______________________________

Have you engaged the service of an attorney?

☐No ☐Yes—Attorney: ______________________________

Address: ______________________________ Phone: ______________

Additional information: ______________________________

____

____

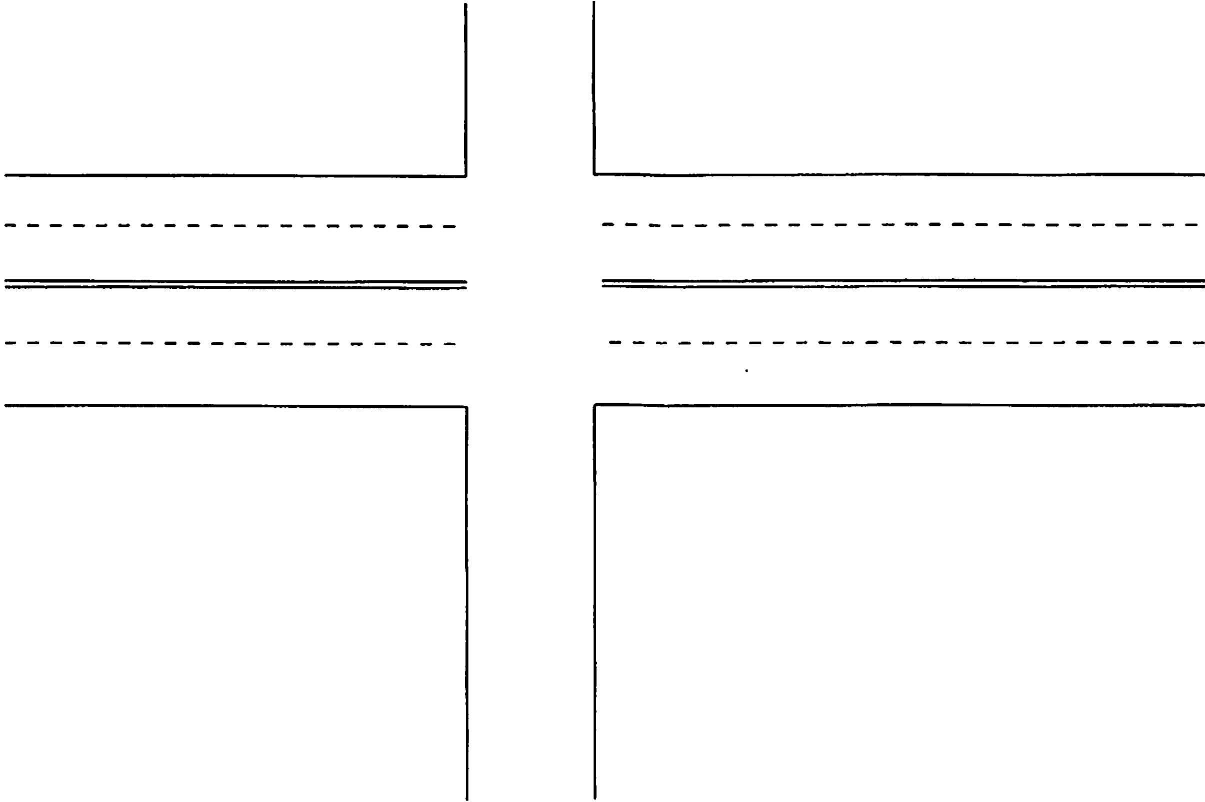
____

____

____

____

Please complete diagram below showing the position of all vehicles, persons, stoplights, stop signs and other objects. Also show street names.



I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that if coverage is denied I am fully responsible for payment.

Patient Name (Please Print)	Patient Signature

Date Signed

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ ***Date*** ____________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** ____________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

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Informed Consent for Care

Please read and sign below:

I, as a patient coming to Los Angeles Chiropractic Clinic, give the doctors permission and consent to care for myself in accordance with appropriate testing, diagnosis, and treatment. The clinical procedures in this office are typically beneficial and rarely have side effects or risks. However, although rare, medical treatments, chiropractic, physical therapy and other treatments do carry a small risk with treatment, including but not limited to: swelling, disc injuries, muscle aches, stroke, and sprains/strains.

I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely on the doctor to exercise judgment during the course of the procedures, which the doctors feel at the time, based on the facts then known, are in my best interest. We use all precautions (exams, x-rays) and gentle treatment procedures to mitigate risk. We cater the care plans to your individual needs.

This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. We also do not provide care for conditions (such as high blood pressure, diabetes, high cholesterol, etc.) other than those addressed in your treatment care plan. Treatment for conditions other those being addressed in our office should be performed by your family physician, or other specialist/provider. We do not prescribe or refill any controlled substances; this aspect should be taken care of by your primary care physician or the original prescriber. The patient assumes all responsibility/liability if the patient does not report on any health forms any past medical history, illnesses, medications, or allergies.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the chiropractors/providers affiliated with Los Angeles Chiropractic Clinic to perform treatment procedures and protocols. I intend for this consent to cover the entire course of treatment for my present condition and any further condition(s) for which I seek treatment for in this office.

________________________________ ____________________

Patient name (Print) Date

____

Patient (or guardian) signature

Privacy Policy Statement

By signing this document, I acknowledge that I have received/read a copy of Los Angeles Chiropractic Clinic's privacy policy. I also acknowledge that I can request a copy of the privacy policy at any time, as well as read the one posted in this office.

________________________________ ____________________

Patient name (Print) Date

____

Patient (or guardian) signature

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at the time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature: ________________________ **Date:** _____________

Restrictions:

Right to revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's and practice may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature: ___________________ **Date:** _______________

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NOTICE OF DOCTORS LIEN

Patient: ______________________ Date of Accident: ______________

I do hereby authorize the doctors practicing at Los Angeles Chiropractic Clinic to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment, and I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

______________ ______________________________

DATED PATIENT'S SIGNATURE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

______________ ______________________________

DATED ATTORNEY SIGNATURE

Los Angeles Chiropractic Clinic Record Release

8711 Venice Blvd, Suite A, Los Angeles, CA 90034
phone: (562) 262-2225 fax: (424) 204-0425

Dr. Ramin Eshghi, DC. Dr. Tyler Clark, DC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: ____________________

Address: ____________________

I, ____________________ Birth Date: ____________ request the following information:

X-Rays History Records   Diagnosis   Reports   Treatment

Concerning my: Illness   Accident   Injury   Other____________

D.O.I:____________

To be released to: Los Angeles Chiropractic Clinic, at the above address.

For the purpose of: Review and Treatment

I understand that I have a right to receive a copy of this authorization upon my request.

Signature: ____________________ Date: ____________

Patient   Spouse   Parent   Guardian