Khalsa Chiropractic

5880 San Vicente Blvd. #101, Los Angeles, Ca 90019 tel 323 857-1277 fax 323 958-1574

CONFIDENTIAL PATIENT INFORMATION

Today's Date________________

Name ____

Cell Phone (________) ______________________________Home Phone (________)______________________________

Address____ City____________________________Zip________________

Age_____________Birth Date________________________ _Marital Status: M S W D How many children?___________

Occupation____

Employer____Work Phone (________)____________________________

In Case of Emergency, Contact:____

Relationship_______________________________________Phone (________)______________________________________

Name of Insurance Company____

Referred by____

Date Symptoms appeared or accident happened____

Patient ever had same or similar condition? ◯ Yes ◯No If yes, when and describe_____________________________

____

Have you lost any days from work?____

Is condition due to injury or sickness arising out of patient's employment? ◯Yes ◯No

Is condition due to injury or sickness arising out of an automobile or other accident? ◯Yes ◯No

Name of Primary Care Physician____

Address____Phone (________)______________________________________

Date of last physical exam_______________________________________ Female: Are you pregnant? ◯Yes ◯No

Past Surgeries____

Serious Illnesses____

Have you ever been under Chiropractic Care? ◯Yes ◯No Doctor's Name___________________________________

Purpose of this appointment (Major complaint):____

____

____

What activities aggravate your condition? ____

Is this condition: ◯Constant ◯Comes and goes ◯Getting progressively worse ◯Improving

Is this condition interfering with your: ◯Work ◯Sleep ◯Daily Routine ◯Other_____________________________

____

How long has it been since you really felt good?____

What do you believe is wrong with you?____

Other doctors seen for this condition____

Have you been treated for any health conditions by a physician in the last year? ◯Yes ◯No

If yes, describe____

What medications or drugs are you taking? ____

____

Remarks and additional information____

____

Check all that apply:

◯ History of recent infection ◯ Recent Fever ◯HIV/AIDS

◯History of stroke. Date of last stroke______________________

Have you ever suffered from:

Past	Present			Past	Present			Past	Present	
		Corticosteroid use				Colitis or other Colon Problems				Alcoholism
		High blood pressure								Drug Addiction
		Dizziness/Vertigo				Indigestion				Swelling of ankles
		Fainting				Constipation				Pain in feet
		Frequent Urination				Diarrhea				Knee problems
		Visual disturbances				Hemorrhoids				Leg pain or sciatica
		Cancer				Bruise easily				Scoliosis
		Diabetes				Sinusitis/sinus infections				Arthritis, location in body:
		Kidney Disease								
		Autoimmune Disease				Depression				Poor Posture
		Heart attack				Panic attacks		**Pain or stiffness in**		
		Aortic Aneurysm				Nausea				Hip
		Osteoporosis				Asthma				Lower back
		Prostrate Problems				Thyroid problems				Middle back
		Epilepsy or seizures				Poor circulation				Neck
		Allergies				Anemia				Shoulder
		Fatigue				Ringing in ears		**Tingling or numbness in**		
		Headaches				Chest pain				Shoulder/arms
		Migraine headaches				Difficulty breathing				Hands
		Ulcers				Hot flashes				Hip/legs
		Abnormal weight gain/loss				Menstrual Pain				Feet
						Insomnia				Groin/Buttocks

Please mark your areas of pain on the figures below.

COMMENTS:

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment

Patient's Signature____________________________________Date________________

Guardian or Spouse's Signature Authorizing Care____________________Date________________