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

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:

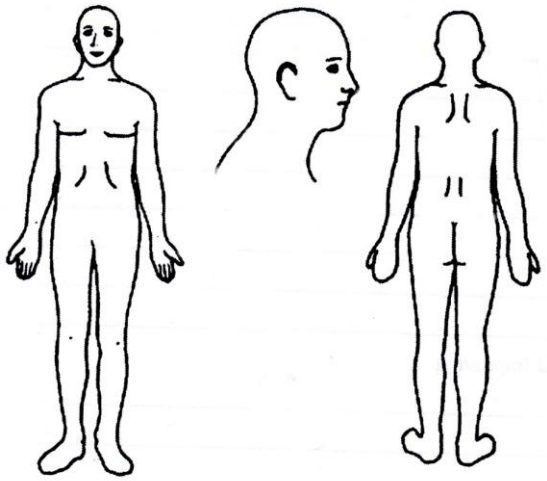
◯ History of recent infection ◯ Recent Fever ◯HIV/AIDS

◯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. 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_____