

REGISTRATION & HEALTH HISTORY

Date: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____

Primary phone#: _____
Alternate phone#: _____
E-mail: _____
Birthdate: _____ Age _____
Married__ Single__ Divorced__ Widowed__ #of Children__
If patient is a Minor, provide parent/guardian name(s): _____
Occupation: _____
Employer/School: _____
Employer address: _____

Employer Phone #: _____
Spouse's Name: _____
Spouse's Occupation: _____
Spouse's Employer: _____
Emergency Contact & #: _____
How did you hear about our office? _____
If found online, what site did you use? _____

INSURANCE INFORMATION

Social Security #: _____
Health Insurance Co: _____
Group # _____ Policy # _____
Insured Name: _____
Birthdate of insured: _____
Relationship to patient: _____

Assignment and release:

I certify that I, and/or my dependents, have insurance coverage with _____ and assign that all insurance benefits, if any, otherwise payable to me for services rendered be paid directly to Bert J. Vanderblik DC or Gabriel Edery DC. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use for 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. This consent is to remain in effect until further notice.
X _____ Date: _____

PATIENT'S CURRENT CONDITION

Reason for today's visit? _____
Is this condition due to an accident? Yes__ No__ Date _____ If yes, please complete personal injury form
When did your symptoms appear? _____
Please rate the severity of your pain from 1-10? (no pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable)
How often are you feeling pain? Constant__ Frequent__ Intermittent__ Occasional__
How would you describe your pain? Sharp__ Throbbing__ Burning__ Dull__ Tingling__ Aching__ Gripping__
Other _____
Are you experiencing any? Numbness__ Weakness__ Soreness__ Stiffness__ Swelling__ Cramping__
What activities are painful: Stand__ Sit__ Lying down__ Walk__ Bend__ Exercise__ Other _____
Does it interfere with your: Work__ Sleep__ Family Life__ Mood__ Daily routines__ Hobbies__ Other _____
Since your pain began, is your condition? Improving__ Getting Worse__ Staying the same__
What would you like to achieve from your care at our office? _____

HEALTH HISTORY

Who is your Primary care physician: _____
Have you been to a chiropractor before? Yes__ No__ If so, Dr's Name _____
When was your last adjustment? _____
Date of last: Physical exam _____ Spinal X-ray _____ MRI – CT – Bone scan _____
Please describe major injuries and any surgical procedures performed: _____

Please list any prescription or over the counter medications &/or supplements you take on a regular basis: _____

Have you been in any accidents? Yes__ No__ If so, When _____
What type? Auto _____ Occupational _____ Personal _____

Continue on back page →

Office Use Only: A-List Text PBA PP SL#1

Please mark all conditions you have ever had, even if they don't seem relate to your current condition

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ankle pain | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Foot pain | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Pins/needles in arms & legs | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Numbness in finger & toes | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Tension/Stress | <input type="checkbox"/> Gallbladder/Liver | <input type="checkbox"/> Problems urinating |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Menstrual Pain |
| <input type="checkbox"/> Finger pain | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Upset stomach | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Wrist pain | <input type="checkbox"/> Fainting/dizziness | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Prostate problems | |
| <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Problem sleeping | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Leg pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ringing in ears | |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Fever | |

Female Patients:
 Are you pregnant? Yes__ No__
 Due date _____

PERSONAL LIFESTYLE

- | | | | |
|-------------------------|---------------------|----------------------|---|
| Exercise/sports: | Work Habits: | Other Habits: | |
| () none | () sitting | () Smoking | how often _____ |
| () mild | () standing | () Drinking | how often _____ |
| () moderate | () light labor | () Coffee/caffeine | how often _____ |
| () heavy | () heavy labor | () Stress | Level 1-10 _____, Personal__ Occupational__ |

On a scale of Poor, Good, Excellent, describe your: Diet: _____ Sleep: _____ General Health _____
 Weight: _____ Height: _____ feet _____ inches

YOUR CHILDHOOD YEARS

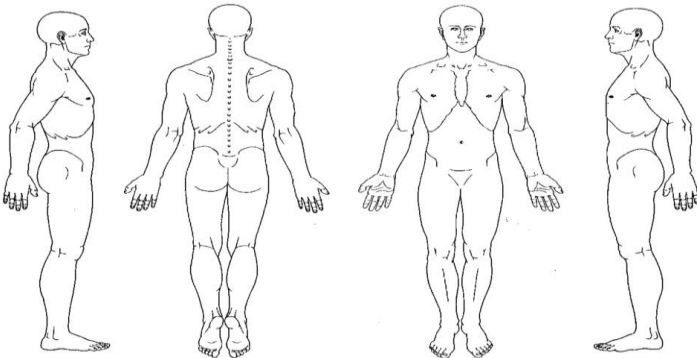
- Did you have any serious illness/conditions? Yes__ No__ When? _____
 Did you have any major surgeries/hospitalization? Yes__ No__ When? _____
 Did you have any major falls/injuries? Yes__ No__ When? _____
 Were you involved in a car accident? Yes__ No__ When? _____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention any health conditions or concerns you may have about your:

Spouse: _____
 Children: _____
 Parents: _____
 Siblings: _____

Mark an X on the areas on this body where you feel the described sensations. Also note (P)Pain (N)Numbness (T) Tingling



On a scale of 0 to 10, rate your level of discomfort

Neck-Shoulder-Arm-Pain
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Severe Pain

Mid Back Pain
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Severe Pain

Low Back and Leg Pain
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Severe Pain

I certify that the statements made on this form are complete and accurate to the best of my knowledge. I agree to notify the doctor immediately if I have any changes in my health condition.

Date _____ Patient Signature _____

Authorization for care of minor:

I herby authorize this office and its doctors to administer care to my son/daughter as they deem medically necessary.

Signature of Patient/Guardian _____ Relationship to minor _____

**Assignment and Instruction for Direct Payment to the Doctor
Private and Group, Accident and Health Insurance**

RE: _____

Patient: _____

Employer: _____

Claim/Group: _____

SS#/Id#: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Bert J. Vanderblik DC
7439 Reseda Blvd.
Reseda, CA 91335

Gabriel Edery DC
7439 Reseda Blvd
Reseda, CA 91335

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Bert J. Vanderblik DC
7439 Reseda Blvd.
Reseda, CA 91335

Gabriel Edery DC
7439 Reseda Blvd.
Reseda, CA 91335

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

Dated at 7439 Reseda Blvd. Reseda, CA 91335 this _____ day of _____, 2014

Signature of Policy Holder

Witness

Signature of Claimant, if other than Policy Holder

Name and address of clinic/office:

Family Wellness A Chiropractic Group
7439 Reseda Blvd.
Reseda, CA 91335

Name(s) of Doctor(s) treating this patient:

Bert J. Vanderblik DC
Gaby Edery DC

INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

Print Patient's Name _____

I hereby request and consent to the performance of procedures which are within the scope of practice of chiropractic including, but not limited to, chiropractic adjustments, various modes of physical therapy and diagnostic x-rays, on me (or on the above named patient, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors 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 above, including those working at the clinic or office listed above or any other office clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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

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 course of treatment for my present condition.

Signature of Patient or Patient's Representative

Print Name of Patient's Representative

Witness to Patient's Signature

Date

Relationship or Authority Representative

Translated by

Date