Reza ChiroMed Center

1009 Wilshire Blvd, Santa Monica 90401, Unit#225

Tel: (424)252-9179
Mobile: (828) 405-0589

DATE:		
LAST NAME:	**FIRST NAME:**	**MIDDLE NAME:**
STREET ADDRESS:		
CITY:	**PROVINCE:** **POSTAL CODE:**	
HOME TEL:	**MOBILE:**	
EMAIL ADDRESS:	**WORK TEL:**	
OCCUPATION:	**EMPLOYER:**	
DATE OF BIRTH (YYYYMMDD):	**GENDER:** ☐ MALE ☐ FEMALE	
MARITAL STATUS:	**SPOUSE NAME:**	
NUMBER OF CHILDREN:	**NAME AND AGES OF CHILDREN:**	
FAMILY DOCTOR'S NAME:	**FAMILY DOCTOR'S TELEPHONE:**	
HOW DID YOU HEAR ABOUT US:		
NAME & NUMBER OF EMERGENCY CONTACT:	**RELATIONSHIP:**	

HISTORY of COMPLAINT

1. **What is the main problem?** _____

2. **How did your main problem begin or how did it happen:**

☐ Car Accident ☐ Slips and fall ☐ Repetitive Stress ☐ Sports injury ☐ Gradually ☐ Suddenly

3. **Is your problem present:**

☐ 100% of the time ☐75% of the time ☐ 50% of the time ☐ 25% of the time ☐ Less than 25% of the time

4. **What does it feel like when it's really bad:**
   ☐ Dull Ache ☐Burning sensation ☐ Sharp/ stabbing pain ☐ Tingles over the area ☐There is numbness
   ☐ Radiates or travels to other places
5. **Is your problem getting:** ☐ Better ☐Worse ☐ Staying the same
6. **When is the problem at its worst?** ☐ Morning ☐ Afternoon ☐Evening ☐ Night
7. **Is the Problem worse when:** ☐ Resting (sitting / lying down for some time) ☐After work/ WITH activity/ when Exercise

8. **When the pain starts how long does it last?**

☐ It is constant (all the time) ☐ On and off during the day ☐ It comes and goes few times during the week

Please Circle the number that best describes your Pain level

- **What is your pain RIGHT NOW?**

(No Pain) 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Extreme Pain)

- **What is the Typical or Average Pain?**

(No Pain) 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Extreme Pain)

- **What is your Pain level at its BEST (ON A GOOD DAY):**

(No Pain) 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Extreme Pain)

- **What is your Pain level at it's WORSE (ON A BAD DAY):**

(No Pain) 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Extreme Pain)

9. Has the problem started to last longer or come more often YET? ☐ YES ☐ NO

10. How does the problem effect your life: ☐ Work ☐ Sleep ☐ Recreation ☐ Family time ☐ Daily Routine

☐ Exercise ☐ Other Areas of life: _____

11. What have you done to in the past to get better?

☐ Nothing ☐ Pain Killers / over the counter stuff ☐ Ice / Heat ☐ Exercise ☐ Other: _____

Did any of the above help? ☐ YES ☐ NO ☐ EXPLAIN: _____

12. Have you suffered with this problem in the past: ☐ YES ☐ NO

☐ **IF YES, how many times?** _____ **When was the last episode:** _____

How did the injury happen? _____

13. Have you seen any other Health Professional for the problem?

☐ No ☐ Chiropractor ☐ Medical ☐ Physiotherapy ☐ Other: _____

14. Have you had any Surgeries? _____

15. What childhood disease did you have? _____

16. List Prescription & Non-Prescription drugs you take INCLUDING vitamins and other Supplements

_____

_____

_____

17. Does anyone in your family have: ☐ Heart problems ☐ Diabetes ☐ Cancer ☐ other: _____

☐ Fibromyalgia, chronic fatigue or multiple chemical sensitivities

PLEASE CHECK ALL SYMPTOMS YOU ARE EXPERIENCING NOW
INDICATE LEFT OR RIGHT

18. SYMPTOMS EXPERIENCING AT THIS TIME

- ☐ Headaches (HA)
- ☐ HA Radiates to Eyes
- ☐ Dizziness
- ☐ Fainting
- ☐ Buzzing/ Ringing in Ears
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Pain in the Jaw
- ☐ Clicking in the Jaw
- ☐ Stiff Neck
- ☐ Neck Pain
- ☐ Shoulder Pain **L R**
- ☐ Elbow Pain L **R**
- ☐ Wrist Pain L **R**
- ☐ Pain going down Arm L **R**
- ☐ Pin/Needles in Arms/Hands L **R**
- ☐ Numbness in Hand/Fingers L **R**
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Upset Stomach
- ☐ Diarrhea
- ☐ Constipation
- ☐ Problem Urinating
- ☐ Menstrual Pain/Irregularity
- ☐ Knee Pain L **R**
- ☐ Ankle Pain L **R**
- ☐ Pain going down Buttock/Leg L **R**
- ☐ Pins/Needles in Legs/Feet/Toes L **R**
- ☐ Numbness in Legs/Feet/Toes L **R**

SOCIAL HISTORY

1. Smoking: ○ cigars ○ pipe ○ cigarettes
How often? ○ Daily ○ Weekends ○ Occasionally ○ Never

2. Alcoholic Beverage: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never

3. Recreational Drug use: ○ Daily ○ Weekends ○ Occasionally ○ Never

Activities of life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Carry Children/Groceries	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting Children / Groceries	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Standing for sometime	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Walking for sometime	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Washing / bathing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to

				Perform
Sweeping / Vacuuming	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Other:	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform

Have you ever had any of the following?

BROKEN BONES	☐ NOW	☐ PAST	☐ NEVER	**Swollen and Painful Joints**	☐ NOW	☐ PAST	☐ NEVER
DISLOCATION	☐ NOW	☐ PAST	☐ NEVER	**STROKE**	☐ NOW	☐ PAST	☐ NEVER
HEART ATTACK	☐ NOW	☐ PAST	☐ NEVER	**DISABILITY**	☐ NOW	☐ PAST	☐ NEVER
TUMORS	☐ NOW	☐ PAST	☐ NEVER	**OSTEO ARTHRITIS**	☐ NOW	☐ PAST	☐ NEVER
CANCER	☐ NOW	☐ PAST	☐ NEVER	**RHEUMATOID ARTHRITIS**	☐ NOW	☐ PAST	☐ NEVER
Headache	☐ NOW	☐ PAST	☐ NEVER	**Double Vision**	☐ NOW	☐ PAST	☐ NEVER
Neck Pain	☐ NOW	☐ PAST	☐ NEVER	**Blurred Vision**	☐ NOW	☐ PAST	☐ NEVER
Jaw Pain	☐ NOW	☐ PAST	☐ NEVER	**Depression**	☐ NOW	☐ PAST	☐ NEVER
Shoulder Pain	☐ NOW	☐ PAST	☐ NEVER	**Irritable**	☐ NOW	☐ PAST	☐ NEVER
Wrist Pain	☐ NOW	☐ PAST	☐ NEVER	**Mood Changes**	☐ NOW	☐ PAST	☐ NEVER
Upper back Pain	☐ NOW	☐ PAST	☐ NEVER	**Learning disability**	☐ NOW	☐ PAST	☐ NEVER
Mid Back Pain	☐ NOW	☐ PAST	☐ NEVER	**ADD / ADHD**	☐ NOW	☐ PAST	☐ NEVER

Low Back Pain	☐ NOW	☐ PAST	☐ NEVER	**Trouble Sleeping**	☐ NOW	☐ PAST	☐ NEVER
Hip Pain	☐ NOW	☐ PAST	☐ NEVER	**Heart Problem**	☐ NOW	☐ PAST	☐ NEVER
Knee problem	☐ NOW	☐ PAST	☐ NEVER	**Chest Pain**	☐ NOW	☐ PAST	☐ NEVER
Ankle Pain	☐ NOW	☐ PAST	☐ NEVER	**Difficulty breathing**	☐ NOW	☐ PAST	☐ NEVER
Numbness / Tingling in Arms, fingers	☐ NOW	☐ PAST	☐ NEVER	**High Blood Pressure**	☐ NOW	☐ PAST	☐ NEVER
Numbness and tingling in feet / toes	☐ NOW	☐ PAST	☐ NEVER	**Heart Burn**	☐ NOW	☐ PAST	☐ NEVER
Ringing in the Ear	☐ NOW	☐ PAST	☐ NEVER	**Ulcer**	☐ NOW	☐ PAST	☐ NEVER
Dizziness	☐ NOW	☐ PAST	☐ NEVER	**Gall Bladder Problems**	☐ NOW	☐ PAST	☐ NEVER
Hearing Loss	☐ NOW	☐ PAST	☐ NEVER	**Liver Troubles**	☐ NOW	☐ PAST	☐ NEVER
Sinus Drainage / Sinus problems	☐ NOW	☐ PAST	☐ NEVER	**Hepatitis (A,B,C)**	☐ NOW	☐ PAST	☐ NEVER
Allergies	☐ NOW	☐ PAST	☐ NEVER	**Digestive System problems**	☐ NOW	☐ PAST	☐ NEVER
Asthma	☐ NOW	☐ PAST	☐ NEVER	**Diarrhea / Constipation**	☐ NOW	☐ PAST	☐ NEVER

HIPAA Personal Health Information Release

I, _____, hereby authorize **Reza ChiroMed Center** to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ○ Spouse Name: _____
- ○ Significant Other Name: _____
- ○ Parent/Legal Guardian Name: _____
- ○ Child (ren) Name(s): _____
- ○ Any Specified Person Name: _____
- ○ Information is not to be discussed with or released to anyone.

Restrictions:

- ○ No Restrictions
- ○ Only discuss my appointment time with the above-named individual(s).
- ○ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ○ Only discuss the health treatment rendered to me with the above-named individual(s).

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at **Reza ChiroMed Center** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date (DD/MM/YY)
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date (DD/MM/YY)

Messages:

Please call ○ My Home ○ My Work ○ My cell phone ○ EITHER ONE IS OKAY TO CALL

Phone Number: _____ - _____ - _____

If unable to reach me:

- ○ You may leave a detailed message
- ○ Please leave a message asking me to return your call
- ○ _____

I understand I may terminate this consent at any time by giving written notice to **Reza ChiroMed Center**. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____