Active Care Chiropractic

Dr. Mark J. Wogahn, D.C
18762 Ventura Boulevard
Tarzana, CA 91356
(818) 342-2299

Health History

Name: _____ Date: _____

Birthdate: _____ Age: _____ Social Security Number: _____

Address: _____ City: _____ Zip: _____

Home Phone Number: _____ Mobile Phone Number: _____

Email Address: _____

Spouse: _____ Children (Name/Age): _____

Occupation: _____ Work Phone: _____

Who referred you to us? _____

Past Chiropractic Care? (Circle one) Yes No Dr.'s Name/Location: _____

Last Visit: _____

Reason(s) for consulting this office: _____

Current Medical Care? (Circle one) Yes No Why? _____

Current Drugs/Medication: _____

Please check the choice that most closely describes your current goals for health/wellbeing.

- □ I am only concerned about relief of a particular symptom.
- □ I am only concerned about relief of a particular symptom, and preventing its return.
- □ I want optimum health and wellbeing on every level available to me.

WE ACCEPT PAYMENT BY CASH, CHECK, AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature: _____ Date: _____

Personal History

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

This interference is most commonly the result of vertebral subluxations.

Stress that may be physical, chemical, or emotional may cause these subluxations.

The practice of chiropractic is based on the location and reduction of nerve system interference caused by the vertebral subluxation

Please tell us about any stress at your birth:

1. Drugs/medicine/tobacco/alcohol in pregnancy? _____
2. Labor chemically induced? _____
3. Forceps/vacuum extraction/C-section? _____
4. Premature delivery? _____
5. Vaccinations? _____
6. Falls in first year of life? _____
7. Any health related problems? _____

Please tell us about any stress associated with childhood:

1. Any falls or injuries? _____
2. Allergy, asthma, or respiratory problems? _____
3. Ear infections? _____
4. Digestive problems? _____
5. Hyperactivity? _____
6. Any other health related problems? _____

Please tell us about any stress up to present:

1. Auto injury? _____
2. Work injury? _____
3. Sports injury? _____
4. Work stress? _____
5. Family/home stress? _____
6. Prescription drug use? _____
7. Non-prescription drug use? _____
8. Ever hospitalized? _____
9. Surgery? _____
10. Major illness? _____
11. Reoccurring illnesses? _____
12. Limited exercise? _____
13. Poor nutrition? _____

Anything else?

_____

_____

Active Care Chiropractic
18762 Ventura Boulevard
Tarzana, CA 91356
(818) 342-2299

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor, or intern, affiliated with Active Care Chiropractic, or Mark Wogahn, D.C..

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, and dislocations. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in the best interests.

_____ I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor, affiliated with Active Care Chiropractic, or Dr. Mark Wogahn, D.C. to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

HIPAA – NOTICE OF PRIVACY POLICY

_____ I have read and received the Privacy Policy Notice (HIPAA) form and understand my rights contained in the notice.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

TERMS OF ACCEPTANCE

These are the terms under which all patients are accepted for care in this office.

It is clearly understood that there is no promise or offer of any kind, on the part of the doctor(s) or this office, to treat any symptom, condition, or disease.

Although I may have come to this office with the initial expectation of relief of a particular symptom or condition, it has been clearly explained to me that the only purpose of chiropractic care is to remove or reduce nerve interference caused by the presence of a vertebral subluxation.

_____ This correction is undertaken for no other reason than that these vertebral subluxations interfere with the capacity of the body to fully express life.

_____ _____
Patient Name Date

_____
Patient or Patient Guardian Signature

Active Care Chiropractic
18762 Ventura Boulevard
Tarzana, CA 91356
(818) 342-2299

FINANCIAL AGREEMENT

Dear Patient:

We have attempted to provide you with the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to Active Care Chiropractic and Dr. Mark Wogahn.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or your guardian.

These policies apply only to the services actually performed and in no way obligate the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I have elected to use the following payment plan to finance my care at Active Care Chiropractic:

_____ 1. **CASH**
- (a) Payment is due at the time of service.

_____ 2. **MEDICARE**
- (a) Payment is due at the time of service.
- (b) Active Care Chiropractic will complete the necessary Medicare forms on my behalf.
- (c) Spinal adjustments are the only form of care paid by Medicare. All other services will not be paid by Medicare.

_____ 3. **PERSONAL INJURY**
- (a) Although my insurance or lawsuit may eventually pay Active Care Chiropractic in full for services rendered, I will pay this office $_____ toward my initial visit, and $_____ per week thereafter, until my bill is paid in full, whether active or inactive as a patient.
- (b) If I do not possess med pay through my auto insurance or health insurance, I will pay $_____ per week until my bill is paid in full, whether active or inactive as a patient.

_____ 4. **INSURANCE POLICY COVERAGE**
- (a) I am responsible for my charges at all times. I will pay Active Care Chiropractic any deductibles owing along with my copay at each of my visits. If care at Active Care Chiropractic exceeds my benefits, I am responsible for my charges, visit by visit.

NOTE: If a payment is not made on the account 30 days from your last visit, or with a 30 day calendar month, a $25 service charge will be applied to maintain the account monthly. Active Care Chiropractic and Dr. Mark Wogahn will refund any overpayments made to us upon completion of care.

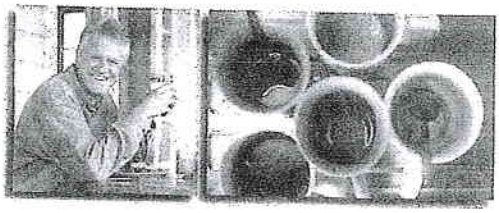
_____ _____
Patient Name Date

_____
Patient or Patient Guardian Signature

PRE-SCAN Checklist for: _____ Date _____

Your nervous system controls and regulates every cell of your body. We use an instrument that reveals how well your nervous system is working.

Please let us know if we need to be mindful of the following:



Drinking coffee or tea can excite the nervous system.
Have you had any of these caffeinated beverages today?

❑ **No** ❑ **Yes**

About ___ cups.

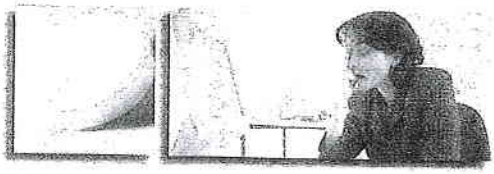
Cola drinks contain caffeine and chemicals that can affect the nervous system.
How many sodas have you had today: _____.

Nicotine is a nervous system stimulant.
Have you used any tobacco today?

❑ **No** ❑ **Yes** How much: _____

Common, over-the-counter drugs can impact the nervous system.
Have you taken any of these types of drugs today?

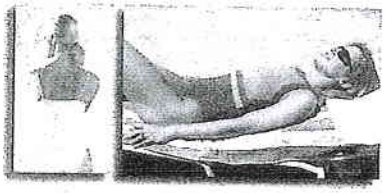
❑ **No** ❑ **Yes:** _____

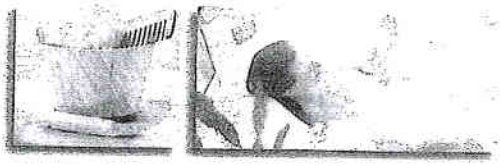


Many prescription drugs and muscle relaxers affect the nervous system.
Have you taken any type of prescription medication today?

❑ **No** ❑ **Yes:** _____

Excessive exposure to the sun affects the accuracy of your scan.
Have you had a sunburn in the last five days? ❑ **No** ❑ **Yes**





Bath salts, oils or sunscreen on your skin can influence instrument sensitivity.
Have you used any of these products today? ❑ **No** ❑ **Yes**

Vigorous physical activity can exaggerate your scan results.
Have you had a workout today? ❑ **No** ❑ **Yes**

Stress, depression, anxiety or emotional upsets can affect nervous system tension.
Compared to a typical day, are you currently experiencing any type of emotional turmoil? ❑ **No** ❑ **Yes**

Name _____ Date _____

Your Current Health Status

Physical State: Rate the following questions on a frequency scale of 1 to 5.

1 = never, 2 = rarely, 3 = occasional, 4 = regularly, 5 = constantly.

1. Presence of physical pain (neck/back ache, sore arms/legs, etc.).	1	2	3	4	5
2. Feeling of tension, stiffness, or lack of flexibility in your spine.	1	2	3	4	5
3. Incidence of fatigue or low energy.	1	2	3	4	5
4. Incidence of colds and flu.	1	2	3	4	5
5. Incidence of headaches (any kind).	1	2	3	4	5
6. Incidence of nausea or constipation.	1	2	3	4	5
7. Incidence of menstrual discomfort.	1	2	3	4	5
8. Incidence of allergies or eczema or skin rash.	1	2	3	4	5
9. Incidence of dizziness or lightheadedness.	1	2	3	4	5
10. Incidence of accidents or near accidents or falling or tripping.	1	2	3	4	5

Mental/Emotional State: Rate the following questions on a frequency scale of 1 to 5.

1 = never, 2 = rarely, 3 = occasional, 4 = regularly, 5 = constantly.

1. If pain is present, how stressed are you about it?	1	2	3	4	5
2. Presence of negative or critical feelings about yourself.	1	2	3	4	5
3. Experience of moodiness or temper or angry outbursts.	1	2	3	4	5
4. Experience of depression or lack of interest.	1	2	3	4	5
5. Being overly worried about small things.	1	2	3	4	5
6. Difficulty thinking or concentrating or indecisiveness.	1	2	3	4	5
7. Experience of vague fears or anxiety.	1	2	3	4	5
8. Being fidgety or restless; difficulty sitting still.	1	2	3	4	5
9. Difficulty falling or staying asleep.	1	2	3	4	5
10. Experience of recurring thoughts or dreams.	1	2	3	4	5

Stress Evaluation: Evaluate your stress relative to the following with,

1 = none, 2 = slight, 3 = moderate, 4 = pronounced, 5 = extensive.

1. Family	1	2	3	4	5
2. Significant Relationship	1	2	3	4	5
3. Health	1	2	3	4	5
4. Work	1	2	3	4	5
5. School	1	2	3	4	5
6. General well-being	1	2	3	4	5
7. Emotional well-being	1	2	3	4	5
8. Coping with daily problems	1	2	3	4	5

Life Enjoyment: Rate the following questions on a degree scale of 1 – 5 with,

1 = extensive, 2 = considerable, 3 = moderate, 4 = slight, 5 = not at all.

1.	Experience of relaxation or ease or wellbeing.	1	2	3	4	5
2.	Presence of positive feelings about yourself.	1	2	3	4	5
3.	Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc.).	1	2	3	4	5
4.	Feeling of being open and aware/connected when relating to others.	1	2	3	4	5
5.	Level of confidence in your ability to deal with adversity.	1	2	3	4	5
6.	Level of compassion for, and acceptance of, others.	1	2	3	4	5
7.	Satisfaction with the level of recreation in your life.	1	2	3	4	5
8.	Incidence of feelings of joy and or happiness.	1	2	3	4	5
9.	Time devoted to things you enjoy.	1	2	3	4	5

Overall Quality of Life: Evaluate your feelings relative to the quality of your life with,

1 = delighted, 2 = pleased, 3 = mostly satisfied, 4 = mixed, 5 = mostly dissatisfied, 6 = unhappy, 7 = terrible.

1.	Your personal life.	1	2	3	4	5	6	7
2.	Your job.	1	2	3	4	5	6	7
3.	Your co-workers.	1	2	3	4	5	6	7
4.	The actual work you do.	1	2	3	4	5	6	7
5.	Your handling of problems in your life.	1	2	3	4	5	6	7
6.	What you are actually accomplishing in your life.	1	2	3	4	5	6	7
7.	Your self.	1	2	3	4	5	6	7
8.	The extent to which you adjust to changes in your life.	1	2	3	4	5	6	7
9.	Your life as a whole.	1	2	3	4	5	6	7

Any other Comments?

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Women's Health Issues
- ❑ Wellness Topics
- ❑ Diet and Nutrition
- ❑ Exercise and Fitness
- ❑ Stress Management

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle
Chiropractic