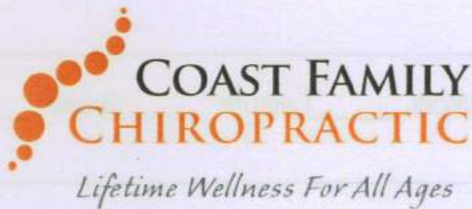


179 E 17th Street, Suite A
Costa Mesa, CA, 92627
Tel (949) 722-7572
Fax: (949) 722-7603

Personal Information:

Name:______________________________ Age:______ Date:______

Address:______________________________ City:/State/Zip:______________________________

Home Phone# ( ) ________-________ Work # ( )__________-__________ Cell #( )______-______

Email Address:______________________________ Male: Female: DOB:______

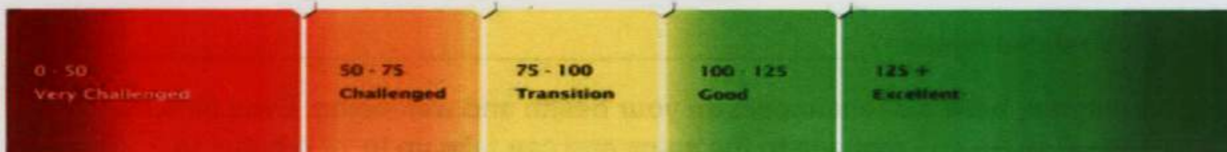
Occupation:______________________________ Employer Name:______________________________

Social Security #______________________________ Status: Single Married Divorced Widowed

# of Children, Names and Ages:______________________________

____

Your Health:



Please place a "X" on the scale above marking where you believe your level of health and wellness is at this time. Place a (0) on the diagram indicating where you would ***like*** your health and wellness to be.

Your Health Profile:

What brings you into our office? Please briefly describe your chief concern, ***including the impact it has had on your life.*** If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" page.

Health Concerns: Rate Severity (1 mild,10 Severe) **When did it start? Did it begin with an injury?**

____

____

____

Since the problem started, it is... ________The Same ________Getting Better ________Getting Worse

What makes the problem worse?______________________________

____

What, if anything makes it feel better?______________________________

Does this interfere with your: ____Work _____Leisure _____Sleep _____Sports _____ Other:______

Have you seen other doctors for this condition? _____Chiropractor _____Medical Dr _____Other:

Was the Health Challenge identified: Yes No

If yes, what was the diagnosis?____

What was the recommended solution?____

General History:

Given that prescription medications are the 3rd leading cause of death in the United States, we are interested in knowing what, if any, medication you are currently taking and for what condition:

____

____

Have you had any surgeries or hospitalizations? Please include all surgeries ____________

____

What do you do for a living?____

Have you ever had any work related injuries?________________________________

Slips and falls, although common, have a direct impact on your health and well-being. Even MINOR falls or accidents cause stress, strain and damage to the spine and can take up to 18 months to heal. If you have had any slips, falls or auto accidents (even minor) Please list them:

____

____

____

____

Please Check (X) all symptoms you have ever had, even if they do not seem related to your current problem:

- ☐ Headaches ☐ Fainting ☐ Neck pain ☐ Asthma
- ☐ Pins and needles in arms ☐ Loss of smell ☐ Back Pain ☐ Loss of Balance
- ☐ Pins and needles in legs ☐ Buzzing in ears ☐ Ringing in ears ☐ Nervousness
- ☐ Numbness in fingers ☐ Numbness in toes ☐ Loss of taste ☐ Fatigue
- ☐ Depression ☐ Irritability ☐ Tension ☐ Sleeping problems ☐ Stiff neck
- ☐ Diarrhea ☐ Constipation ☐ Fever ☐ Hot Flashes ☐ Cold Sweats
- ☐ Lights bother eyes ☐ Urinary problems ☐ Heartburn ☐ Mood Swings
- ☐ Menstrual Pain ☐ Menstrual Irregularity ☐ Ulcers ☐ Allergies

On a Scale of 1-10 describe your psychological/emotional stress levels: (1= none/10 extreme)

Occupational: ______________________________

Personal: ______________________________

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits:_____ Exercise habits:_____ Sleep: _____ General Health______ Mind Set______

Your Goals: At our office we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your Health and Wellness in the space provided.

Physical Goals:	**Nutritional/Biochemical Goals:**	**Psychological Goals:**

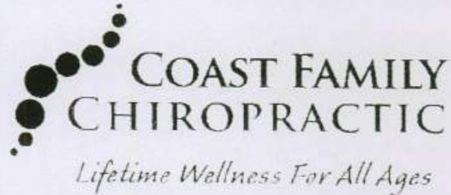
Have you ever:

Bought bottled water	☐ Yes ☐ No
Belonged to a health club	☐ Yes ☐ No
If there is a need for dietary changes would you like to know?	☐ Yes ☐ No
If there is a need for specific exercises would you like to know?	☐ Yes ☐ No
If there is need for support in the psychological/mind/body/stress Dimension of health would you like assistance?	☐ Yes ☐ No

I consent to a professional and complete chiropractic examination and any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature______________________________ Date:______________________

Thank you for filling out this form. It is your first step to Creating Wellness!
Return this to our staff and someone will be right with you.



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 Coast Family Chiropractic.

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, dislocations and sprains. 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, is in my best interests.

The Probability of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during the examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one in a million chance of such an outcome. Since even that risk should be avoided, we look at risk factors and will perform tests to identify if you may be susceptible to that kind of injury, if necessary. The other complications are also generally described as "rare".

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Coast Family Chiropractic 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.

________________________   ________________

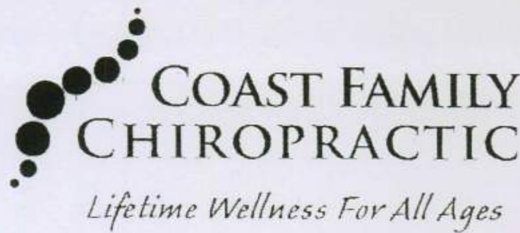
Patient's Name (Please Print)   Date

____

Signature of Patient

____

Parent or Guardian's signature



Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column, which causes alterations or nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. ***OUR ONLY PRACTICE OBJECTIVE*** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________ have read and fully understand the above statements.

All question regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore I accept chiropractic care on this basis.

______________________________ ______________________________

(sign) (date)

Consent to evaluate and adjust a minor child:

I, ______________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge, I am not pregnant and Dr. Escobedo and his associate(s) have my consent to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. ________________

______________________________ ______________________________

(sign) (date)

COAST FAMILY CHIRPRACTIC
ROD ESCOBEDO, D.C.
179 E. 17th Street, Ste A
Costa Mesa, CA 92627
Phone 949 722-7572 Fax 949 722-7603

CONSENT TO BRING IN INSURANCE PAYMENT FOR CHIROPRACTIC SERVICES

Dear Patient:

Please be advised that your healthcare provider (Coast Family Chiropractic or Rod Escobedo, DC) may not be "in network" with your insurance (i.e. the healthcare provider is considered an "out of network" provider).
Your insurance may send the check for our services payable directly to you.
Please understand ***that the check is to pay for the chiropractic services that you received*** at our offices by or on behalf of Coast Family Chiropractic or Rod Escobedo, DC ***and not in any way a payment or reimbursement to you.***

Please read and sign statement below. We sincerely appreciate your cooperation and understanding.

Thank you,

Coast Family Chiropractic, Inc
Rod Escobedo, D.C.

CONSENT TO BRING IN INSURANCE PAYMENT FOR CHIROPRACTIC SERVICES

I understand that I may receive a check from my insurance company for services rendered by or on behalf of Coast Family Chiropractic, Inc (Rod Escobedo, DC) that may be payable to my name instead of the proper payee-Coast Family Chiropractic, Inc (Rod Escobedo)-due to my specific insurance company regulations.
If I do receive such a check from my insurance company, I will notify the office immediately and either mail or bring a personal check or a cashier's check in the same amount payable to Coast Family Chiropractic, Inc to the office ***within 5 calendar days of having received it***.
I will also provide a copy of explanation of benefits (or EOB) that usually accompanies the payment.
Alternately, I *may also pay the balance with* a credit care, money order or cash with the same time frame. My failure to do so in a timely manner may cause further collection attempts from the service provider and may result in additional collection charges to me.

I have read and understood the above consent and promise to comply with the above.

Signature______________________________ Date____________________

Name______________________________