Application for Care at Tabrizi Family Chiropractic

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐Male ☐Female
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____Mobile Phone:_____
Marital Status: ❑Single ❑Married ❑Divorced Work Phone: _____ Fax:_____
Do you have Insurance: ❑Yes ❑No Company: _____ Social Security #: _____
Employer: _____ Occupation: _____
Spouse's Name: _____Spouse's Employer: _____
Number of children and Ages: _____
Name & Number of Emergency Contact: _____Relationship: _____
Whom may we thank for referring you to this office? → _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling *the number:***

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ worst possible pain
0 1 2 (3) 4 5 (6) 7 8 (9) 10

1 – What is your pain RIGHT NOW?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

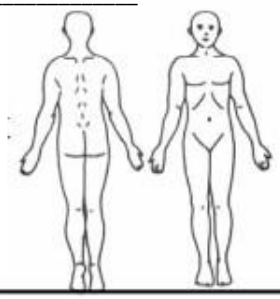
No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐AM ☐PM ☐mid-day ☐late PM
How long does it last? ☐It is constant **OR** ☐I experience it on and off during the day **OR** ☐It comes and goes throughout the week

How did the injury happen?_____
Condition(s) ever been treated by anyone in the past? ☐ No ☐Yes **If yes,** when: _____ by whom? _____
How long were you under care: _____ What were the results? _____
Name of Previous Chiropractor: _____**☐N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
For Example: Lifting	***Can lift approximately 5 pounds***	***Normally can lift up to 30 pounds***
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐Yes ☐No

Patient's Name: _____ Patient Signature:_____ Date: ___/___/___

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

Please mark any other symptoms you have experienced marking the following:

P for in the ***Past,*** **C** for ***Currently have*** and **N** for ***Never have had***

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfunction	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain (Right / Left)	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain (Right / Left)	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List any other medical/psychiatric conditions that have been previously diagnosed:

_____

_____

_____

List any previous surgeries or other major medical procedures you have had:

_____

_____

_____

List Prescription & Non-Prescription drugs you take & How long you have been taking them:

_____

_____

_____

_____

_____

Patient's Name: _____ Patient Signature:_____ Date: ___/___/___

Activities of Daily Living

Daily Activities: Effects of Current conditions On Performance

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

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Patient's Name: _____ Patient Signature:_____ Date: ___/___/___

PAST HISTORY

Have you suffered with any of your current complaints or a similar problem in the past? ❑No ❑Yes **If yes** how many times? _____
When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐No ☐Yes **If yes,** please state **what type of treatment**: _____,
and who provided it: _____ **How long ago? _____What** were the results. ☐Favorable ☐Unfavorable
please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past,*** **C** for ***Currently have*** and **N** for ***Never have had:***

___ Broken Bone ___Dislocations___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular___ other serious conditions: _____
_____

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
4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following:

IDENTIFY TYPE:	**EFFECT:**			
_____	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
_____	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
_____	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
_____	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑grandmother ❑grandfather ❑mother ❑father ❑sisters ❑brothers ❑son(s) ❑daughter(s)
Have they ever been treated for their condition? ❑No ❑Yes ❑I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑No ❑Yes: _____

I hereby authorize payment to be made directly to Tabrizi Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Tabrizi Family Chiropractic for any and all services I receive at this office.

Patient's Name: _____ Patient Signature:_____ Date: ___/___/___

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING

Our office provides care in an "open door" adjusting environment. Adjustments are done in an open adjusting area. As a result patients are in sight of each other and some ongoing routine details of care may be in earshot of other patient's and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity. In addition your signature below authorizes us to contact you at all the phone numbers/address you list on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ❑ **RELIEF CARE:** Symptomatic relief of pain or discomfort of acute/new injuries
- ❑ **CORRECTIVE CARE**: Relief care plus correction of chronic dysfunctions and degenerative changes.
- ❑ **LIFESTYLE CARE:** I would like to have Chiropractic treatment as part of my lifestyle to keep me functioning at my highest capacity.

Office Policy and What You Should Expect On Your First Two Visits

Our office policy is designed to ensure that every patient in our office is treated with the highest level of service.

The First Visit:

Your first visit at Tabrizi Chiropractic is known as **Discovery**. This visit is designed to perform a thorough examination that reveals the underlying conditions that may be causing you symptoms. These tests may be medically necessary to ensure a proper diagnosis. The treating doctor reserves the right to refuse treatment if the patient refuses any of the following tests. Testing that may be performed includes the following:

- Complete history
- Family history
- Chiropractic, orthopedic, neurological testing
- X-ray examination

Insurance/Treatment Fees:

The fee for the initial examination is $275, **unless otherwise indicated by promotions**. NOTE: insurance reimbursement is not guaranteed by your insurance company. It is your responsibility to verify coverage of services with your insurance company**.** Although we accept most insurance and perform a complementary in office benefit analysis, if your insurance company refuses payment, it is your responsibility to properly compensate Tabrizi Family Chiropractic for your co-pay, co-insurance, deductible, or charges not covered by insurance for services rendered.

Second Visit:

It is our policy to review X-ray findings and process X-ray film thoroughly before beginning any kind of treatment. X-ray processing is usually done overnight and can take up to 24 hours. Once your X-rays have been processed and reviewed, the doctor will prepare your second visit, the Report of Findings, which is a 25 minute consultation designed to thoroughly discuss your X-ray and exam findings, provide proper recommendations, and answer any questions you might have.

Treatment Session:

Treatment lasts between 15 and 25 minutes per sessions, which includes advanced chiropractic adjustments, myofascial release (deep tissue muscle therapy), intersegmental traction for the lumbar spine, and traction for the cervical spine (unless otherwise indicated).

Treatment is never performed on the first visit without proper review of X-Ray findings unless otherwise indicated by the doctor.

The fee for the first visit of treatment is $80. Fee is due at the time of service unless insurance verification has been provided and discussed with the doctor. If treatment is rendered on the initial examination before insurance coverage is determined, the fee is $80. If your insurance company proves coverage, this fee will be reimbursed. Please allow 24 hours for insurance verification in office. If you do not have insurance coverage, cash discounts are offered to make your care affordable. Cash discounts are based on number of treatments necessary and discussed on your **(report of findings- 2nd visit).** Should you need a specific time to spend more time with a doctor to ask questions or need special attention, please make accommodations to schedule a 20 minute consultation with the front desk.

Appointments:

- There is no fee for changing your chiropractic appointment time with an advance phone call (minimum 2 hours' notice).
- There is a $25 cancellation fee for all missed massage appointments. There is no fee for cancelled massage appointments with a 24 hour notice.
- If you need to make accommodations for an appointment that exceeds the typical office visit, please do so in advance.

Please be respectful of other patient's time and privacy in our office. We are looking forward to being a part of your change! Welcome to Tabrizi Family Chiropractic!

Patient's Name: _____ Patient Signature:_____ Date: ___/___/___

Informed Consent to Treat

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment used by a Doctor of Chiropractic is spinal manipulative therapy. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles which is just a sound of gas releasing between the joint.

Analysis/ examination/ treatment:

As a part of analysis, examination and treatment, you are consenting to the following procedures: **Please Circle All**

Spinal Manipulative Therapy
Range of Motion Testing
Muscle Strength Testing
Palpation
Manual Physiotherapy
Orthopedic Testing
Postural Analysis
Radiographic Studies
Hot/Cold Therapy
Vital Signs
Basic Neurological Test
Traction Therapy
Electrical Stimulation Therapy

Other (please explain):_____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The probability of these complications occurring is extremely rare. Fractures are rare occurrences and generally result from some underlying weakness of the bone, such as osteoporosis or infection, which are checked for during the taking of your history and during examination and x-rays. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are generally described as rare. It is important that you are thorough on describing any previous conditions or underlying conditions that you may be suffering from.

Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction, further reducing mobility. Over time this process may complicate treatment, making it more difficult, and less effective the longer it is postponed. The ultimate goal is not only symptomatic relief, but correction of any underlying musculoskeletal conditions.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Patient's Name: _____ Patient Signature:_____ Date: ___/___/___

Tabrizi Family Chiropractic

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____
What speed was the collision? _____
Type of impact: Front Impact / Side Impact / Rear Impact
Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____
Please describe the manner of the injury _____
Was treatment received? Please describe _____
Does your job require you remain in long term stressful postures?_____
(i.e. *all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? _____
Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____
Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____
Work around the house – lifting, bending, woke up with stiff neck, "back went out"

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) Values?_____

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you eat breakfast daily from Monday to Friday? (Y / N) _____

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly:
_____
_____
_____

Patient's Name: _____ Patient Signature:_____ Date: __/___/___

INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular ___Hours ___Days/Wk Weight Training ___Hours ___Days/Wk

Low Impact (Yoga, etc.) ___Hours ___Days/Wk

What is your target weight? _____What is your current weight? _____

How willing are you to change any of these things to reach your health goals? ***(Scale of 1-10)*** **_____**

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Does your home, work, school, or car have damp or mildew smell? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received? _____ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night (Y/N)

Do you average less than 7 hours of sleep per night (Y/N)

Do you ever take pills to go to sleep or relax (Y/N)

Do you often feel short on time and procrastinate on projects? (Y / N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)

Do you rely more on your memory than a planner and action list to get things done? (Y / N)

Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

Patient's Name: _____ Patient Signature:_____ Date: __/___/___

Doctor Signature _____ Date _____