

PATIENT INFORMATION FORM

Today's Date ____/____/____

ABOUT YOU

Name: _____ What you prefer to be called: _____

Birthdate: ____/____/____ Age: _____ SS#: ____-____-____ Male ____ Female ____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____ Referred By: _____

Employer: _____ Occupation: _____

Marital Status: ____ Minor ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed

Spouse's Name: _____ Any children? ____ Y ____ N How Many? _____

REASON FOR VISIT

The reason for this visit is a result of: ____ Work ____ Sports ____ Auto ____ Trauma ____ Chronic

Explain what happened: _____

Please describe the pain & its location: _____

When did this condition begin? ____/____/____ Is it getting worse? ____ Y ____ N ____ Constant ____ Comes & Goes

Is this condition interfering with your : ____ Work ____ Sleep ____ Daily Routine

If so, please explain: _____

Have you had this or a similar condition in the past? ____ Y ____ N

If so, please explain: _____

Have you been treated by a medical physician for this condition? ____ Y ____ N

If so, where? _____

Have you ever been treated by a chiropractor before? ____ Y ____ N Were X-Rays taken? ____ Y ____ N

If so, whom? _____ Phone: _____

INSURANCE: If you have insurance that may cover chiropractic, please provide your current insurance card so that we may make a copy.

IN CASE OF EMERGENCY

Who should we contact? _____ Relation: _____

Home Phone: _____ Work Phone: _____

Who is your medical doctor? _____ Phone: _____

HEALTH HISTORY

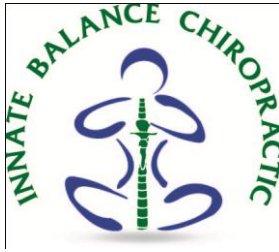
Are you taking any of the following medications? ____ Pain medication (including aspirin) ____ Muscle relaxers

____ Blood thinners ____ Insulin ____ Anti-Inflammatories ____ Other(s) _____

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Do you have or ever had any of the following diseases or conditions?

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Artificial Valves |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV+/Aids | <input type="checkbox"/> Shingles | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Arthritis _____ |

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any past serious accidents with dates: _____

Family Health History: _____

DO YOU:

Take supplements or vitamins? Y N If so what?: _____

Exercise? Y N Do you smoke? Y N How much? _____ How long? _____

Are you on a special diet? Y N Since: ___/___/___

Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

What is the age of your mattress? _____ Is it comfortable? Y N

FOR WOMEN:

Are you taking birth control? Y N

Are you pregnant? Y N How far along? _____ Nursing? Y N

ACCOUNT INFORMATION

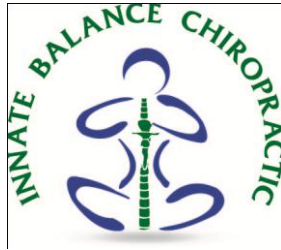
** I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.*

** Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of date of service and no other financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.*

** I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.*

** I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.*

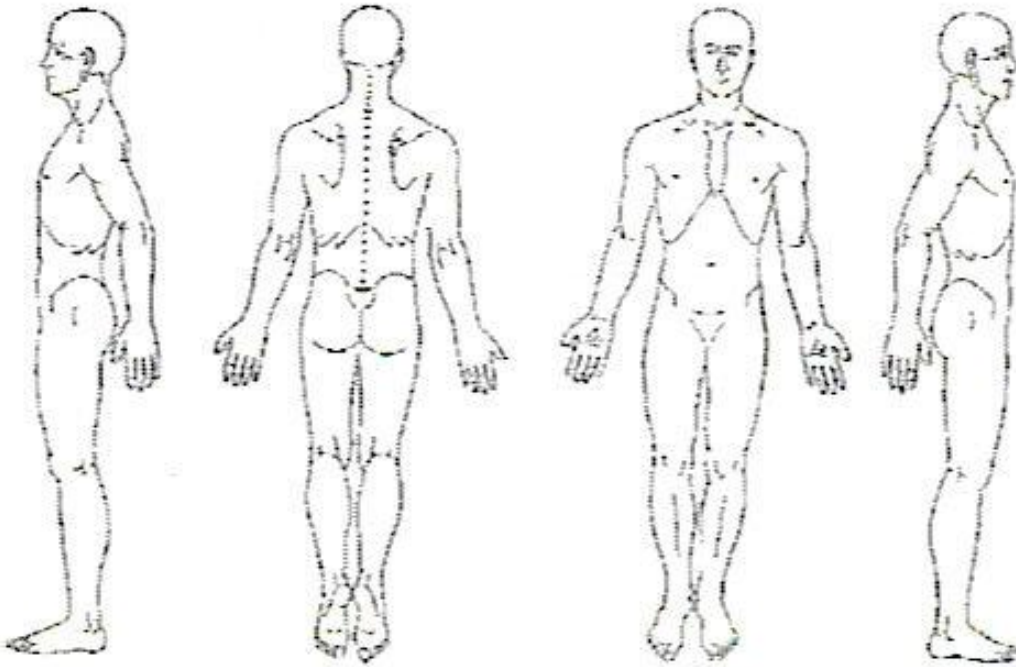
Signature: _____ Date: ___/___/___



Description of Condition

Mark any area(s) of discomfort with the following key:

A = Ache N = Numbness B = Burning T = Tingling S = Stiffness O = Other



Left

Back

Front

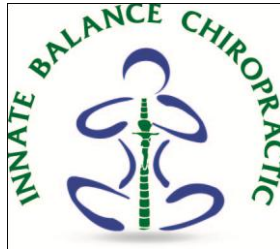
Right

On a scale of one to ten how intense are your symptoms? Not intense ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

Printed Name:

Signature

Date



Consent to Exam and Treat

The undersigned consents to examination which may include physical, orthopedic, neurological, laboratory, and radiographic as needed to evaluate and or diagnose the patient. The undersigned also consents to therapeutic procedures as are deemed necessary by their doctor in the course of treatment. These therapeutic procedures may include any of the following: Spinal and extraspinal manipulation/adjustments, ice, heat, electrical muscle stimulation, ultrasound, laser/light therapy, soft tissue manipulation, taping, exercise, nutritional supplementation and any other procedures as prescribed by the doctor.

The staff of this office does everything within their power to minimize any risk involved in any procedure. In spite of that, there is a very small risk of complications. These complications can include, but not limited to, increased pain, swelling, bruising, clicking, sensory changes, bleeding, fracture, dizziness, weakness or stroke. Again, complications are exceedingly rare; however, it is necessary to inform you of their possibility.

I have read the above information and by my signature give my consent for evaluation, examination and treatment. I understand that I may question any procedure at any time. I also understand that I may decline any procedure I am not completely comfortable with.

Printed Name: _____
Signature: _____ Date: _____

Financial Responsibility Agreement

I fully understand that Innate Balance Chiropractic has agreed to complete and submit insurance claims on my behalf to my insurance carrier. In the process of filling such claims, it is often necessary to release copies of my records. I give my full and complete permission to Innate Balance Chiropractic to release my records to any party necessary for my treatment or payment of such.

I also understand that the submitting of a claim in no way guarantees payment for the claim. I therefore, understand and acknowledge that I also am fully and completely responsible for the total bill.

I agree to pay Innate Balance Chiropractic for any and all charges, which result from my care, in the office at the time the care is rendered. (Exceptions will only be made with prior approval from the Doctor). In the event that any overpayment occurs, Innate Balance Chiropractic will credit your account or refund said funds, whichever you prefer.

Responsible Party/Patient Signature Date

Signature of Doctor Date