GOVERNOR'S PARK
CHIROPRACTIC

Beginning chiropractic care is the first and most important step on your journey towards good health. Please answer all questions on this form completely and honestly. This information will help your doctor of chiropractic determine the best treatment plan for your condition. If you have any questions concerning this form or your future care with our office, please do not hesitate to ask any of our staff members.

Contact Information

Patient Name _____ Female Male

Date of Birth _____ Age _____ Social Security # _____-_____-_____

What would you prefer to be called? _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____

Email Address _____

Mother's Name _____ Father's Name _____

Legal Guardian: Mother & Father Mother Father Other: _____

Emergency Contact Information

Name _____ Home Phone _____

Relationship to You _____ Work Phone _____

Consent to Treat a Minor

I authorize Dr. Omid Ferdowsian, D.C., DACBSP, CCEP to examine and treat the above named minor.

Minor's Parent or Guardian Signature: _____

Referral Information

Who or what may we thank for sending you to our office? _____

Billing Information

Person Ultimately Responsible for Account: _____Relationship to Patient _____

Insurance Company _____ ID # _____

Primary Insured's Name _____ Relationship to Patient _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Date of Birth _____

Primary Insured's ID # _____ Primary Insured's SS_____-_____-_____

Employer _____ Work Address _____

Our policy requires payment in-full for all services rendered at the time of your visit, unless other arrangements have been made with our office manager. Your signature below shows that you understand and agree to our financial policy and that you authorize our staff to perform any necessary services needed during diagnosis and treatment.

Signature _____ Date _____

Health History

Patient Name _____ Date _____

Primary Care Physician _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip Code _____

Do you have x-rays? Yes [Date _____] No Do you have other films (ie MRI)? Yes [Date _____] No

We would like to remain in contact with your primary care physician and specialists, as required, during your course of treatment with our clinic to help improve the continuity and quality of your care. This contact will include phone calls and the delivery of reports or films to your PCP as needed. This release can be canceled or limited at any time in writing. Your signature below shows that you understand and agree with our request.

Signature _____ Date _____

Are you currently seeing any specialists in addition to your PCP? No Yes (Please list names & addresses below)

Medical History including specialists, surgeries, medications, accidents _____

_____

_____

Height _____ Weight _____ Left or Right Handed? _____

Have you or an immediate family member ever experienced any of the following diseases or medical conditions?

C – current medical condition **P** – past medical condition **F** – immediate family member

Respiratory and Cardiovascular

____ Difficulty Breathing ____ Asthma ____ Sinus Problems ____ Chest Pain
____ High/Low Blood Pressure ____ Congenital Heart Defect. ____ Heart Murmur ____ Heart Attack
____ Anemia ____ Stroke ____ Other _____

Musculoskeletal

____ Severe/Freq. Headaches ____ Broken Bones ____ Frequent Neck Pain ____ TMJ Syndrome
____ Muscle Sprain/Strain ____ Lower Back Problems ____ Spinal Surgery ____ Herniated Disc
____ Osteoporosis ____ Spina Bifida ____ Other _____

Gastrointestinal

____ Ulcers ____ Nausea ____ Diarrhea/Constipation ____ Bloody Stools
____ Intestinal Ulcers/Colitis ____ Difficult Bowel Movmnt ____ Other _____

Genitourinary

____ Incontinence ____ Difficult Urination ____ Kidney Issues ____ Prostate Pain/Disorders

For Women Only

____ Uterine Fibroids ____ Ovarian Cysts ____ PCOS ____ Severe Menstrual Cramping
____ Number of Pregnancies ____ Other _____

Ears, Nose and Throat

____ Hearing Issues ____ Visual Disturbances ____ Other _____

Neurological

____ Epilepsy/Seizures ____ Dizziness/Fainting Spells ____ Migraines ____ Multiple Sclerosis
____ Psychiatric Disorders ____ Other _____

General Health History

____ Diabetes ____ Cancer ____ Gout ____ General Fatigue
____ Sudden Weight Loss/Gain ____ Shingles ____ Hepatitis ____ HIV+/AIDS
____ Alcohol/Drug Abuse ____ Insomnia ____ Arthritis ____ Other _____

Pregnancy/Birth History

Type of Birth: Vaginal Cesarean Location of Birth: Home Hospital Other: _____

Birth Complications: Forceps/Vacuum Breech Other _____

Please Describe Complications During Pregnancy and Birth _____

_____

Birth Weight _____ Birth Length _____ Feeding: Breast milk Formula Both

Hours Child Sleeps at Night _____ Number of Naps Per Day _____ Quality of Sleep: Good Fair Poor

Immunization History _____

Number of Siblings _____ Name(s), Age(s), and Gender(s): _____

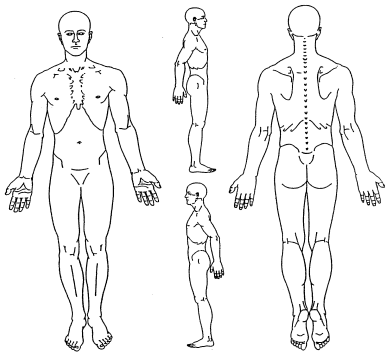
_____

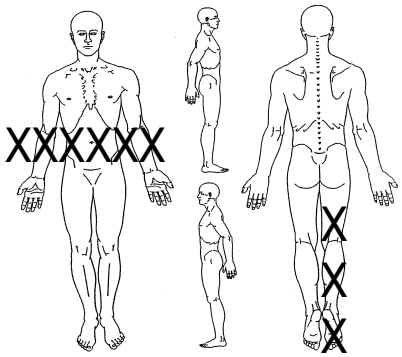
Current Complaint

○ Wellness Check-Up, no complaints

Mark Areas of Pain:

Example:





Please describe the quality of the pain that has brought you to our office today _____

_____

Pain is worse Morning Mid-Day Afternoon Night With Activity With Rest Other: _____

Pain is better Morning Mid-Day Afternoon Night With Activity With Rest Other: _____

What do you believe has caused this pain?_____

Please rate your overall pain on a scale from 1 [little to no pain] to 10 [worst pain you have experienced] _____

Chiropractic Care Goals

____ Achieve and Maintain Full Body Health ____ Increase Range of Motion ____ Improve Overall Body Function

____ Treat Specific Condition or Injury ____ Improve Nutrition ____ Reduce Pain Only

Signature _____ Date _____