Governor's Park
CHIROPRACTIC

Welcome To Our Office

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., C.C.E.P. to examine and treat the above named minor.

Minor's Parent or Guardian Signature: _____

Billing Information

Person Ultimately Responsible for Account: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other: _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Social Security # ____-____-_____ Driver's License _____ State _____

Employer _____ Work Address _____

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____-____-_____

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 _____

Referral Information

We would like to personally thank the person, physician, or attorney who referred you to our office.

I was referred by:

☐ Existing Patient ☐ My Physician ☐ My Attorney ☐ My Insurance ☐ The Yellow Pages ☐ Other: _____

Her/His Name _____ Phone Number _____

Address _____ City _____ State/Zip _____

Health History

Previous Chiropractor _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip Code _____

Please describe the symptoms or injures your previous chiropractor was treating _____

_____

Were x-ray films taken? ☐ Yes [Date _____] ☐ No Were MRI films taken? ☐ Yes [Date _____] ☐ No

Primary Care Physician _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip Code _____

Were x-ray films taken? ☐ Yes [Date _____] ☐ No Were MRI films taken? ☐ 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)

Physician's Name Specialty Address

_____

_____

Current Medications/Supplements Reason for Taking Prescribing Doctor Dosage

_____

_____

Previous Surgeries Reason Surgeon Date

_____

_____

Please list all known allergies (include food allergies): _____

_____

Previous Serious Accidents and Injuries (auto, falls, etc.): _____

_____

Height _____ Weight _____ Left or Right Handed? _____

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

Health History Continued

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): _____

_____

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	_____ Tuberculosis
_____ Congenital Heart Defect	_____ Chest Pain	_____ Anemia	_____ _____

Musculoskeletal

_____ Severe/Freq. Headaches	_____ Difficulty Walking	_____ Joint Pain/Soreness	_____ Broken Bones
_____ Frequent Neck Pain	_____ TMJ Syndrome	_____ Muscle Sprain/Strain	_____ Spina Bifida
_____ Lower Back Problems	_____ Muscle Spasms	_____ "Growing Pains"	_____ _____

Gastrointestinal

_____ Stomach Aches	_____ Nausea	_____ Diarrhea/Constipation	_____ Difficult Bowel Mvmnt

Genitourinary

_____ Bed Wetting	_____ Difficult Urination	_____ Kidney Stones	_____ Kidney Disorders

Ears, Nose and Throat

_____ Loss of Hearing	_____ Ringing in the Ears	_____ Visual Disturbances	_____ Epiglottitis
_____ Tonsillectomy	_____ Chronic Ear Aches	_____ Sinus Trouble	_____ _____

Neurological

_____ Epilepsy	_____ Dizziness	_____ Fainting Spells	_____ Migraines
_____ Loss of Memory	_____ Seizures	_____ Psychiatric Disorders	_____ _____

General Health History

_____ Diabetes	_____ Cancer	_____ Chemotherapy	_____ Gout
_____ General Fatigue	_____ Rheumatoid Fever	_____ Allergies [food/medicine]	_____ Sudden Weigh
_____ Chicken Pox	_____ Skin Grafts	_____ Hepatitis	_____ HIV+/AIDS
_____ Hyperactivity	_____ Insomnia	_____ Arthritis	_____ Difficulty Sleeping
_____ Behavioral Problems	_____ Poor Appetite	_____ Ruptures/Hernias	_____

Lifestyle

_____ Exercise Regularly	_____ Sleep 8+ hrs per night	_____ Wear Orthotics	_____ Wear Lifts

Current Complaint

☐ Wellness Check-Up, no complaints

Please describe the quality and location 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 ☐ Sports Physical

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

Signature _____ Date _____