



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 injuries 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
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Current Medications/Supplements	Reason for Taking	Prescribing Doctor	Dosage
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Previous Surgeries	Reason	Surgeon	Date
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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 Mvmt

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 _____