CONFIDENTIAL PATIENT HISTORY

Date: _____
Patient # _____

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____
Address _____ City _____ ST _____ Zip _____
Phone (H) _____ (W) _____ (C) _____
Email _____
Occupation _____ Employer _____
Spouse's Name _____ D.O.B _____ Spouse Ph _____ Employer _____
Children's Name & Ages

Have you had previous Chiropractic care? ☐yes ☐no Whom? _____

Who may we thank for referring you to our office? _____ ☐Walk In ☐Advertisement ☐Promotion ☐Yellow Pages
Who is your primary care physician? _____ Address: _____
Phone: _____ Date of last physical/exam? With Whom? _____ When doctors work together, it benefits you. May we update your medical doctor regarding your treatment in our office? ☐yes ☐no

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____
Date when symptom first appeared _____ How Did it begin: _____
How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%
Have you ever experienced the same or similar symptoms? ☐yes ☐no When? _____
Have you been to another doctor for this problem? ☐yes ☐no Who/Where? _____
Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? _____
Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other _____ ☐Does not radiate
What makes the symptoms increase? _____ What relieves the symptoms? _____
Drugs you now take: ☐Nerve Pills ☐Pain Pills ☐Muscle Relaxer ☐Blood Pressure ☐Other: _____
Do any family members suffer from the same complaint? If so, who? _____

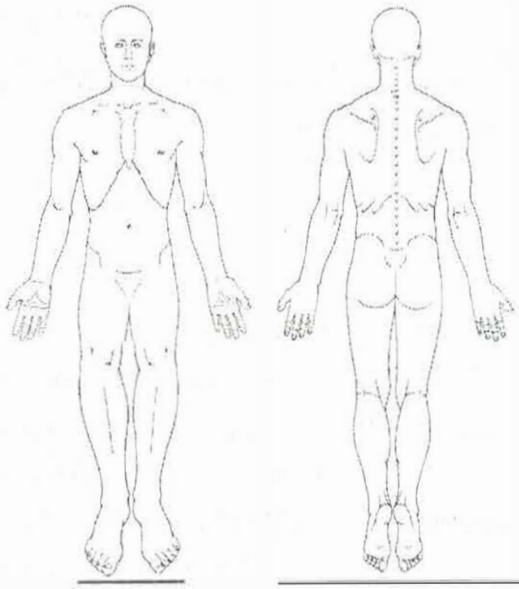
SECONDARY COMPLAINT: _____
Date when symptom first appeared _____ How Did it begin: _____
How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%
Have you ever experienced the same or similar symptoms ☐yes ☐no When? _____
Have you been to another doctor for this problem? ☐yes ☐no Who/Where? _____
Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? _____
Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other _____ ☐Does not radiate
What makes the symptoms increase? _____ What relieves the symptoms? _____

Age of Mattress _____ ☐Comfortable ☐Uncomfortable

Have you ever been in an auto accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never
Please describe: _____
Please list all surgeries, injuries, accidents, falls, etc: _____

Please mark off all areas of complaint on the diagrams with the following indicators:

A=ache
D=dull
N= numbness
T= tingling
B= burning
S=sharp/stabbing
X = other



Please list any medications or vitamins you are currently taking (including dosage).

_____

_____

_____

_____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ◦◦◦ 1 ◦◦◦ 2 ◦◦◦ 3 ◦◦◦ 4 ◦◦◦ 5 ◦◦◦ 6 ◦◦◦ 7 ◦◦◦ 8 ◦◦◦ 9 ◦◦◦ 10

Do you smoke? ☐yes ☐no If yes, how many packs per week?_____ **Have you ever smoked in the past?** ☐yes ☐no When did you quit?_____
Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____
Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____
Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____
Do you have a high stress level? ☐yes ☐no If yes, list reasons:_____ _____

Is there any possibility that you may be pregnant? ☐yes ☐no **Date of Last Menstrual Cycle** _____

Please check if you have had any of the following:

☐ Headaches/ Migraines	☐ Arthritis	☐ Anxiety/Depression	☐ Joint Pain/ Stiffness	☐ Rheumatoid Arthritis
☐ Low Back Pain	☐ Fatigue	☐ Digestive Problems	☐ Diabetes	☐ Parkinson's Disease
☐ Dizziness	☐ High Cholesterol	☐ AIDS/ HIV	☐ Osteoporosis	☐ Disc Degeneration
☐ Allergies	☐ Loss of Sleep	☐ Kidney Disease	☐ PMS/ Cramps	☐ Menstrual Problems
☐ Pinched Nerve	☐ Sciatica	☐ Sinus Pain	☐ Pacemaker	☐ High Blood Pressure
☐ Cancer	☐ Tumors/ Growths	☐ Urinary Problems	☐ Vascular Disease	☐ Heart Disease/ Problems
☐ Paralysis	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain	☐ Stroke
☐ Thyroid Problem	☐ Fibromyalgia	☐ Arm/Leg Pain	☐ Jaw Pain/ Clicking	☐ Vision Problems
☐ Neck Pain	☐ Glacoma	☐ Asthma	☐ Numbness/ Tingling	☐ Prostate Problems
☐ Other:				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Neuroedge Chiropractic* will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Neuroedge Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or pay to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: Date: _____

Date: _____
Patient # _____

Automobile Accident History

Last _____ First _____ Middle Initial _____ Birth Date _____ Age _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____

Occupation _____ Employer _____

Spouse's Name _____ Business/Employer _____ Spouse Phone: _____

Who is your primary care physician? _____ Address: _____

Phone: _____ Date of last physical/exam? _____ With Whom? _____

Date of Accident: _____ Time of Accident: _____ am / pm ☐Daylight ☐Dawn ☐Dusk ☐Dark

Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other _____

Was the accident on the job? ☐Yes ☐No Where you in a company vehicle? ☐Yes ☐No

Where were you seated in the vehicle? ☐Driver ☐Passenger ☐Rear-seat ☐Other _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise

Did you lose consciousness upon impact? ☐Yes ☐No Did you experience a flash of light or explosion in your head? ☐Yes ☐No

Did the police come to the accident scene? ☐Yes ☐No Is there a police report? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No When? ☐Immediately ☐___hours later ☐___days later Which hospital? _____

How did you get to the hospital? _____ How long did you stay in the hospital? _____

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)_____

What areas were x-rayed? _____ What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? ☐Yes ☐No If yes, please complete information below.

Dr. _____ Specialty? _____ Date first seen: _____

Type of treatment: _____ Treatment frequency: _____ How long did you treat? _____

Dr. _____ Specialty? _____ Date first seen: _____

Type of treatment: _____ Treatment frequency: _____ How long did you treat? _____

Were you wearing a seatbelt? ☐Yes ☐No If yes, did you receive any injury or bruise from the seat belt? ☐Yes ☐No

Did your head hit the head rest during the accident? ☐Yes ☐No If adjustable, was the position of the head rest altered? ☐Yes ☐No

Was the seat adjustment altered by the accident? ☐Yes ☐No Was the seat broken by the accident? ☐Yes ☐No

Did the air-bag deploy? ☐Yes ☐No If yes, did it strike you? ☐Yes ☐No If yes, where? _____

Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left Body? ☐Straight ☐Right ☐Left

Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Not Applicable

Were you wearing a hat or glasses at the time of impact? ☐Yes ☐No If so, were they still on after the accident? ☐Yes ☐No

YOUR CAR

List the year, make and model of the car you were in: YEAR: _____ MAKE: _____ MODEL: _____

Was your car stopped at the time of impact? ☐Yes ☐No If yes, was the driver's foot on the brake? ☐Yes ☐No If no, estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it: ☐Slowing down ☐Gaining speed ☐Steady speed

THE OTHER CAR

List the year, make and model of the other car : YEAR: _____ MAKE: _____ MODEL: _____

Was the other car moving at the time of impact? ☐Yes ☐No If yes, what was the approximate speed of the vehicle : _____mph

At the time of impact, was the other car: ☐Slowing down ☐Gaining speed ☐Steady speed

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

_____

_____

_____

You may draw the accident here

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim #:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

Driver of the other vehicle: _____ **Name of their auto insurance:** _____

Policy #: _____ **Claim#:** _____

Auto insurance phone #: _____ **Name of insurance adjuster:** _____

At the time of the accident, did you become or experience any of the following? ☐Confused ☐Disoriented ☐Light headed ☐Dizzy ☐Nauseated ☐Blurred vision ☐Ringing/Buzzing in ears ☐Loss of balance ☐Other: _____

Do you still have any of those symptoms? ☐Yes ☐No **If yes, which ones?** _____

Brain/Neuro/Psych/MTBI symptoms

☐ Wanting to be Alone	☐ Disoriented	☐ Difficulty Speaking	☐ Forgetting Numbers	☐ Day Dreaming/Mindless Staring
☐ Sleepiness	☐ Confused	☐ Attention Problems	☐ Indecisiveness	☐ Feelings of Isolation from Others
☐ Nausea/ Vomiting	☐ Agitation	☐ Pupils Different Sizes	☐ Reduced Confidence	☐ Difficulty Focusing/Easily Distracted
☐ Difficulty Concentrating	☐ Mood Swings	☐ Room Spins/ Woozy	☐ Helplessness	☐ Difficulty with Adding/Subtracting
☐ Balance Problems	☐ Very Tired	☐ Difficulty Walking	☐ Apathy (Don't Care)	☐ Difficulty Learning New Things
☐ Appetite Change	☐ Reading Problems	☐ Dozing During the Day	☐ Irritable	☐ Re-reading Things to Understand It
☐ Sadness or tearful	☐ Writing Problems	☐ Personality Change	☐ Flashbacks to Accident	☐ Change in Sexual Functioning
☐ Blurry Vision	☐ Poor Attention	☐ Difficulty Understanding	☐ Impatience	☐ Change in Sense of Taste or Smell
☐ Hearing Problems	☐ Anger	☐ Difficulty Remembering	☐ Frustration	☐ Difficulty Planning or Organizing

CURRENT COMPLAINTS -List current symptoms separately in order of severity.

1* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

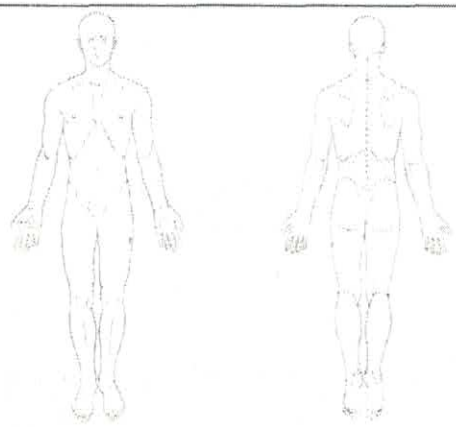
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0◇◇◇1◇◇◇2◇◇◇3◇◇◇4◇◇◇5◇◇◇6◇◇◇7◇◇◇8◇◇◇9◇◇◇10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



2* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

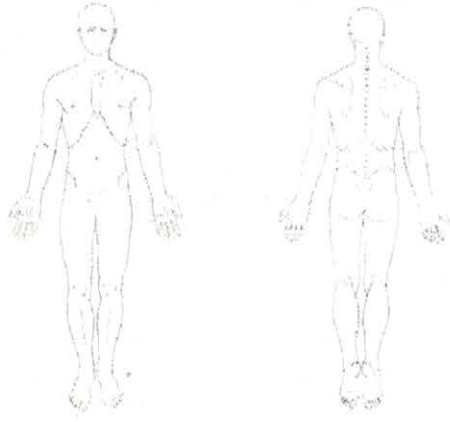
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0◇◇◇1◇◇◇2◇◇◇3◇◇◇4◇◇◇5◇◇◇6◇◇◇7◇◇◇8◇◇◇9◇◇◇10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



3* Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

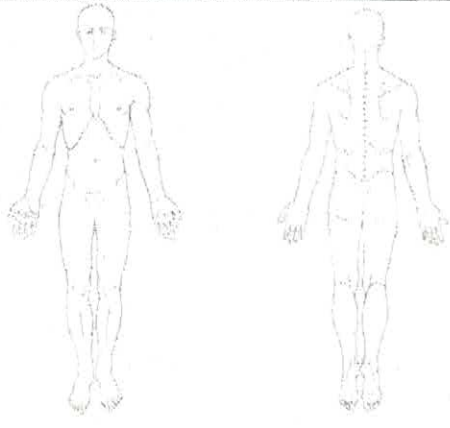
Type of pain? ☐Sharp ☐Dull ☐Aching ☐Burn ☐Throb ☐Numb ☐Other_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0◇◇◇1◇◇◇2◇◇◇3◇◇◇4◇◇◇5◇◇◇6◇◇◇7◇◇◇8◇◇◇9◇◇◇10

Where does pain radiate to? _____

Please mark areas of pain on the figures below



OCCUPATIONAL INFORMATION

Job involves: ☐Sitting ☐Standing How long? _____ ☐Lifting How much? _____ ☐Bending ☐Twisting ☐Turning ☐Stooping

Physical activity at work: ☐Sedentary ☐Light manual labor ☐Manual labor ☐Heavy manual labor

Have you missed any time from work due to the accident? ☐Yes ☐No If yes, how many days? _____ Dates: _____

Are your work activities restricted as a result of this accident? ☐Yes ☐No If yes, please explain._____

Do any of your work activities aggravate your present main complaints? ☐Yes ☐No If yes, please explain. _____

_____

Do you smoke? ☐yes ☐no If yes, how many packs per week?_____Have you ever smoked in the past? ☐yes ☐no When did you quit?_____

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons:_____

Please list any medications or vitamins you are currently taking (including dosage).

_____ Frequency:_____ Dosage: _____ What is this for? _____

_____ Frequency:_____ Dosage: _____ What is this for? _____

_____ Frequency:_____ Dosage: _____ What is this for? _____

_____ Frequency:_____ Dosage: _____ What is this for? _____

X-RAY CONFIRMATION - FEMALES

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____

Patient Signature Date

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____

Patient Signature Date

AUTHORIZATION FOR CARE OF MINOR

CONSENT TO TREAT A MINOR: I hearby authorize the doctor(s) at *Neuroedge Chiropractic* and whom ever they designate as assistants to administer care to child.

Name of Child / Minor (please print) _____ _____ ___

Name of Parent / Guardian (please print) _____

Parent / Guardian signature: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Neuroedge Chiropractic as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care.

We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.

Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered or approved by their insurance plan.

Copays are due at the time of service.

Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

PRINT PATIENT NAME:_____

PATIENT SIGNATURE:_____ DATE:_____

PARENT OR GUARDIAN must sign if patient is under 18 years of age

SIGNATURE:_____ DATE:_____

Authorization For Care

I hereby authorize the Doctor to work with my condition through the use of the adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills insured at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignments of my insurance rights and benefits (if applicable) directly to provider of services rendered.

X _____ X _____

Patient Signature Guardian Signature

Who should receive bills for payment on your account?

☐Patient ☐Spouse ☐Parent ☐Work Comp ☐Medicare ☐Personal Health Insurance ☐Auto Insurance

Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company _____

ID # _____

Group # _____

Address _____

Phone Number _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Neuroedge Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Neuroedge Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) Date

_____

Patient or Guardian's Signature

AUTHORIZATION OF DIRECT PAYMENT AND DOCTOR'S LIEN

Account #

To:

_____

_____

_____

Neuroedge/Dr. Carlson
25032 Las Brisas RD #A
Murrieta, CA 92562
Office (951) 304-2242
Fax (951) 304-0403

D/O/A_____

I do hereby authorize the doctor(s) of Neuroedge/ Dr. Carlson to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I give my power of attorney to Neuroedge/ Dr. Carlson for the endorsement of any payments received from my insurance company and / or attorney.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

_____ _____

Date Patient Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named and to issue such sums withheld to the above named doctor.

_____ _____

Date Attorney Signature

Please date, sign and return original to Neuroedge/Dr. Carlson. Please keep a copy for your records.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO:_____

ADDRESS:_____

I, _____request the following information:

__ x-ray ____ History ___ Records _____ Diagnosis _____Treatment _____ Records

concerning my: ___ Accident ____ Injury ___ Illness ___ Other_____

To be released to : Neuroedge Chiropractic
Dr. Marty Carlson D.C
25032 Las Brisas Rd #A
Murrieta, CA 92562
(951) 304-2242 fax: (951) 304-0403

For the purpose of:_____

According to section 123.110 of the California Health & Safety Code, these records/ films must be provided within 15 days of your receipt of this notice.

Signed: _____ Date:_____

___ Patient ____ Spouse ____ Parent ____ Guardian