J.GREGORY LAVEN, D.C.

Placentia, CA 92870
(714) 528-7500

Date ______________

(PLEASE **PRINT**)

PATIENT INFORMATION

Name ______________________________

Address ______________________________

City ______________ State _____ Zip __________

Birth Date ____________

Phone # ______________ Cell Carrier ____________

Age __________ Sex ☐ Male ☐ Female

E-MAIL: ______________________________.

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Referred by ______________________________

EMPLOYER INFORMATION

Employer ______________________________

Employer Address ______________________________

City ______________ State _____ Zip __________

Business Phone # ______________ ext. __________

Occupation ______________________________

REASON FOR CONSULTATION

What are your present complaints and symptoms? __________

____

Is your condition a result of a: Work Injury? ☐ Yes ☐ No

Auto accident? ☐ Yes ☐ No Other ______________

Date of Injury or Onset ______________________________

Family physician ______________ Phone __________

RESPONSIBLE PARTY INFORMATION

Name ______________________________

Relation: ☐ Self ☐ Spouse ☐ Other ______________

Social Security # ______________ Date of Birth __________

Phone ______________ Work __________ ext __________

Address ______________________________

City ______________ State _____ Zip __________

Employer ______________________________

Employer Address ______________________________

City ______________ State _____ Zip __________

Occupation ______________________________

If patient is child, other parent's name ______________

Phone ______________ Work __________ ext: __________

Address ______________________________

City ______________ State _____ Zip __________

Occupation ______________________________

INSURANCE INFORMATION

Are you insured? ☐ Yes ☐ No

Insurance Company ______________________________

Other Insurance Company ______________________________

(Please Present insurance cards to the receptionist.)

EMERGENCY CONTACT

Name ______________________________

Relationship ______________ Phone __________

CONSENT OF TREATMENT OF MINOR

I (We) being the parent or guardian of the above patient, a minor, of the age ___ do hereby consent, authorize and request Dr. Laven, and whomever he may designate as his assistant, to administer such treatment deemed advisable, necessary or requested for this minor.

______________________________ Date ______________

Signed (Parent or Legal Guardian)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

______________________________ Date ______________

Signed (Insured Person)

PERSONAL HEALTH HISTORY

Name:______________________________ Date:____________

General Information

Height: Feet: ________ Weight: ________

Inches: ________

Do you consider yourself:

() Alert () Calm () Nervous
() Irritable () Fatigued () Depressed
() Run Down

Do you consider yourself:

() Well Developed () Average Developed
() Under Developed () Well Nourished
() Average Nourished () Under Nourished
() Large Build () Medium Build
() Small Build

WOMEN ONLY:

Are you currently Pregnant? () Yes () No
Date of last period: ____________
Date of last breast exam: ____________
Date of last pap smear: ____________
Do you experience? () Cramping () Irregularity
() Menstural Pain

MEN ONLY:

Date of last prostate exam:

____

MEDICATIONS NOW TAKING:

____

____

Allergies:

() None () Asprin () Pollen
() Foods () Codeine () Cats/Dogs
() Penicillin () Dust
() Other ____________

Surgeries:

Type of Post

() Appendix () Kidney () Mastectomy
() Tonsils () Hernia () Other ____________
() Gall Bladder ____________
() Hysterectomy

Have you ever been disabled? () Yes () No

Dates: ____________

Education:

Last grade level completed: ____________

Illness:

() AIDS () Anemia () Arthritis
() Asthma () Blindness () Bronchitis
() Cancer () Cataracts () Chicken Pox
() Cirrhosis () Colitis () Duodenal Ulcer
() Diabetes () Depression
()Emphysema () Epilepsy
() Enlarged Heart () Gall Stones
() Gastritis ()Glaucoma () Gonorrhea
() Gout () Goiter () Hay Fever
() Heart Disease () Hepatitis
() Hernia () HIV () Kidney Stones
() Jaundice () Malaria () Measles
() Mumps () Mononucleosis
() Nephritis () Paralysis () Phlebitis
() Pneumonia () Pleurisy
() Polio () Psoriasis () Scarlet Fever
() Syphilis () High Cholesterol
() Rheumatic Fever () Tuberculosis
()Hypothyroid () Hyperthyroid
() High Blood Pressure () Low Blood Pressure
()High Triglycerides
() Other ____________
() Other ____________

Family Medical History:

please identify illnesses within your immediate family

() Arthritis () Diabetes
() Emphysema () Epilepsy
() Hypertension () Heart Disease
() Migranes () Peptic Ulcer
() Renal Disease () Rheumatic Fever
() Rheumatoid Arthritis () Strokes
() Obesity () Cancer () Tuberculosis

Do you suffer from sleep loss? () Yes () No
Do you smoke or use tobacco? () Yes () No
Do you drink alcoholic beverages? () Yes () No
Do you drink caffeinated beverages? () Yes () No

Matial Status:

() Single () Married () Seperated
() Divorced () Widowed

Number of Children: ____________

____

PATIENT SIGNATURE

HEAD:

() Headache

- () Entire Head
- () Back of Head
- ()Forehead
- () Right Temple
- () Left Temple
- () Mirgaine

() Head feels heavy ()Loss of memory
() Light-Headedness () Fainting
() Light bothers eyes ()Loss of balance
() Loss of smell () Loss of taste
() Dizziness () Loss of hearing
() Pain in ears () Ringing in ears
() Buzzing in ears

NECK:

() Pain in neck

Neck pain is worse when:

() Bending Forward () Bending Backward
() Bending Right () Bending Left
() Turning Right () Turning Left
() Sensation of Pinched Nerve
() Neck feels out of place
() Muscle spasms in neck
() Grinding or grating sounds in the neck
() Popping sounds in the neck
() Arthritis in the neck

MID-BACK:

() Mid back pain

Mid back pain is worse when:

() Bending Forward () Bending Backward
() Bending Right () Bending Left
() Turning Right () Turning Left
() Pain between shoulder blades
() Sharp stabbing pain in mid-back
() Muscle spasms in mid-back

CHEST:

() Chest Pain () Athsma
() Shortness of breath ()Cough
()Pain around ribs

ABDOMEN:

() Nervous Stomach () Constipation
() Nausea () Gas () Diarrhea

LOW -BACK:

() Low back pain

Low back pain is worse when:

() Bending Forward () Bending Backward

LOW-BACK CONT.

() Bending Right () Bending Left
() Twisting Right () Twisting Left
() Walking () Sitting () Standing
() Coughing () Sneezing () Wheezing
() Stooping () Lifting () Bowel Movements
() Pinched nerve in lower back
() Low back feels out of place
() Tailbone pain

Tailbone pain is worse when:

() Bending Forward () Bending Backward
() Being Right () Beinding Left
() Twisting Right () Twisting Left
() Walking () Sitting ()Standing
() Working () Lifting () Stooping
() Coughing () Sneezing () Bowel movements
()Muscle spasms in low back
()Arthritis in low back

SHOULDERS:

() Pain in shoulder joint () R () L
() Pain across shoulders
() Bursitis () R () L
() Arthritis () R () L
() Cant Raise Arm

- () Above shoulder level
- () Over head

() Tension in Shoulders
() Pinched nerve in shoulder () R () L
() Muscle spasms in shoulder () R () L

ARMS & HANDS:

() Pain in upper arm () R () L
() Pain in forearm () R () L
() Pain in hand () R () L
() Pain in wrist () R () L
() Pain in fingers () R () L
() Pinched nerve in arm () R () L
() Pinched nerve in finge () R () L
() Sensation of pins and needles
() Arm ()Fingers () R () L
() Fingers go to sleep () R () L
() Hands feel cold () R () L
() Swollen joints in finger () R () L
() Sore Joints in fingers () R () L
() Arthritis in fingers () R () L
() Loss of grip strength () R () L

HIPS, LEGS & FEET

() Pain in buttocks () R () L

HIPS, LEGS & FEET CONT.

Buttock pain is worse when:

()Bending Forward
() Bending Backward
() Bending Right
() Bending Left
() Twisting Right
() Twisting Left
() Walking () Sitting ()Standing
() Working () Lifting () Stooping
() Coughing () Sneezing
() Bowel movements
() Pain in hip joints () R () L

Pain in hip joints is worse when:

()Bending Forward
() Bending Backward
() Bending Right
() Bending Left
() Twisting Right
() Twisting Left
() Walking () Sitting ()Standing
() Working () Lifting () Stooping
() Coughing () Sneezing
() Bowel movements
() Pain down Legs () R () L

Leg pain is worse when:

()Bending Forward
() Bending Backward
() Bending Right
() Bending Left
() Twisting Right
() Twisting Left
() Walking () Sitting ()Standing
() Working () Lifting () Stooping
() Coughing () Sneezing
() Bowel movements
() Leg Cramps () R () L
() Sensation of pins and needles () R () L
() Numbness in legs () R () L
() Numbness in feet () R () L
() Numbness in toes () R () L
() Feet feel cold () R () L
() Cramps in feet () R () L
() Swollen Ankles () R () L
() Swollen joints in toes () R () L
() Painful joints in toes () R () L

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

____
Printed name of Patient

x___________________________________ ______________
Signature of Patient Date

x___________________________________ ______________
Signature of Representative Date
(if patient is a minor or is handicapped)

x___________________________________ ______________
Witness to Patient's Signature