South Bay Wellness Center
General Information

Name (First): ________________________ Middle: ___________ Last:_____________________ Date:______________

Date of Birth: _____________________ Age: _______ Gender: Male/ Female

Marital Status: Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner ❑

Phone ❑ Cell ❑ Home: ____________________ Other Phone ❑ Home ❑ Work: ___________________ Ex. _______

Address:____ Apt. No: _______ City: ________________________________

State:__________ Zip Code: _______________

Email: **Referred By:**

EMERGENCY CONTACT

Name: ____________________________________ Relationship: ____________________________

Phone No❑ Cell ❑ Home: ___________________ Other Phone No ❑ Home ❑ Work: _________________ Ex. ____

IF UNDER 18 YEARS OF AGE: (Parent or Legal Guardian must sign Authorization to Treat a Minor Form)

Guardian Name: ________________________ Relationship: _____________ Guardian Signature: ________________

Phone No ❑ Cell ❑ Home: _______________________ Other Phone No ❑ Home ❑ Work: _____________________

EMPLOYMENT

Disabled❑ Unemployed❑ Permanent❑ Temporary❑ Work Full Time❑ Work Part Time❑ Student❑ Retired❑

Occupation or Nature of Work: _________________________ Name of Employer: ________________________

Work Address:____________________________ Suite No: __________ City:_________________________

State: ________ Zip Code: ______________ Work Phone No: ______________________

INSURANCE INFORMATION

(If present insurance card no need to fill out)

Name of Insurance: ______________________________ Phone Number: ________________________

Insurance ID#:_______________________ Group#:____________________ Insureds Name: ______________________

Insureds DOB: ______________Insurance Address:____ Suite No:_________

City:_______________________________ State: ________ Zip Code:________________

Have you been in any previous accidents? Yes / No Date: _______________ Did you get any treatments? Yes / No

Nature of Injury: ❑Motor Vehicle Accident ❑Work Related Injury ❑Fall ❑Traumatic Event ❑ Gradual Onset

❑Ongoing/Chronic Condition ❑Unknown Onset ❑Other________________________________

Name of Attorney if you are represented by one: ___________________________ Phone No.: ___________________

Please place one of the following numbers on the line in front of the symptom:
By number most Important #1Worst needs attention at this moment #1 = problem (s) I wish to be treated for NOW, to the list # (2,3…)=problem/s I might wish to be treated for AT A LATER DATE

HEAD and NECK

___ Headache
___ Neck pain with movement
___ Neck pain without movement
___ Stiff neck
___ Muscle spasms in neck
___ Grinding sound in neck
___ Radiation of pain into arms or hands
Comments: ______________________

SHOULDERS

L R
___ ___ Pain in shoulder joints
___ ___ Pain across shoulder
___ ___ Tension in shoulder
___ ___ Unable to raise arm overhand
___ ___ Weakness in arms
Comments: _________________________

ARMS and HANDS

L R
___ ___ Pain in upper arms
___ ___ Pain in elbow
___ ___ Pain in hand
___ ___ Pain in fingers
___ ___ Sensation of pins and needles in arms
___ ___ Sensation of pins and needles in hands
___ ___ Cold hands
___ ___ Swollen joints in fingers
___ ___ Stiffness in fingers
___ ___ Loss of grip strength / weakness

MID BACK

L R
___ ___ Mid back pain
___ ___ Pain between shoulder blades
Comments: _______________________

LOW BACK

___ Low back pain
___ Low back with radiation into buttock or leg
___ Muscle spasms
Comments: _______________________

HIPS, LEGS, and FEET

L R
___ ___ Pain in hip
___ ___ Pain in knee
___ ___ Pain in back of leg
___ ___ Pain in front of leg
___ ___ Leg cramps
___ ___ Sensation of pins and needles in legs
___ ___ Numbness in feet
___ ___ Cramps in feet
___ ___ Pain in ankles
___ ___ Swollen ankles
___ ___ Foot pain
___ ___ Numbness in toes
___ ___ Weakness in legs
Comments: ________________________

Symptoms and Present of Health

In a few words describe your condition? ____

Are you experiencing numbness or tingling in any area of your body? ____

When did your pain or discomfort start? ____

What type of pain are you having? ☐Sharp ☐Dull / Ache ☐Constant ☐Intermittent ☐Other

Does this pain shoot, radiate, or travel in your body? ☐ Yes ☐ No Where to? _________________________________

Since it began is your pain the? ☐ Same ☐ Better ☐ Worse

Frequency of pain? Occasional= 0-25% Intermediate =25-50% Frequent = 50-75% Constant = 75-100%

Do you experience or have had any of these symptoms with your current problem,

☐Headache ☐Nausea ☐Vomiting ☐High Blood Pressure ☐Vison Problems

☐Diarrhea/Bowel Movement Problems Numbness: Location ____________ when _________ other ____________

PATIENT NAME: DATE:

Doctors name: Kian M. Javid, D.C. **Signature:**

What activities aggravate your condition / pain? ____
What activities lessen your condition / pain? ____
Is this condition worse during certain times of the day? ____
Is this condition interfering with ☐Work ☐Sleep ☐Daily Routine ☐Other: ____________________
Is this condition progressively getting worse? ☐YES ☐ NO
Have you seen any doctors for this condition? ☐YES ☐ NO If yes whom: ________________________

What is your goal from your treatment today?.____.

Short term goal from Chiropractic treatment? .____.

Long term goal from Chiropractic treatment? .____.

Please Circle where you are at: if (you are at No Pain = 0 or your Worsen pain = 10)

Your # 1Area of complaint: ____________ (No Complaint/Pain = 0 1 2 3 4 5 6 7 8 9 10 = **Worst** Possible

Your # 1Area of complaint: ____________ (No Complaint/Pain = 0 1 2 3 4 5 6 7 8 9 10 = **Worst** Possible

Your # 1Area of complaint: ____________ (No Complaint/Pain = 0 1 2 3 4 5 6 7 8 9 10 = **Worst** Possible

Your # 1Area of complaint: ____________ (No Complaint/Pain = 0 1 2 3 4 5 6 7 8 9 10 = **Worst** Possible

Do you have this pain now? ☐YES ☐ NO Has your pain level decreased since it started? ☐YES ☐ NO
Is your pain the same all the time? ☐YES ☐ NO

Using the symbols below, mark on the pictures where you feel pain/s.

Ache: OOO

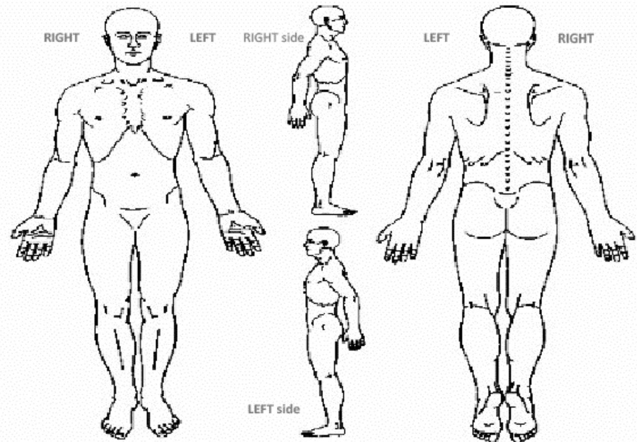
Numbness: = = =

Burning: XXX

Sharp / Stabbing: ///

Pins, Needles: +++

Other: ____________________ ^ ^ ^



Self History:
Any recent illness: ______________________________

Are you taking medication for this condition? ☐YES ☐ NO If yes what: ________________________________

Last check up by your physician: Less than one year? When:__________ OR More than one year? When: __________
Have you had surgery? ___________________________ If yes when & for what? ____________________
FEMALES ONLY- Last time checked by OB/GYN: ☐Less than one year ago ☐More than one year ago
Do you smoke? ☐YES ☐ NO Drink alcohol: ☐YES ☐ NO How much/often? ______________________
Do you take Vitamins or Supplements: ☐YES ☐ NO If yes what? __________________________
Do you have any history or any of these illnesses: ☐Heart Disease, ☐Arthritis, ☐Cancer, ☐ Diabetes
Is there Family History of: ☐Arthritis ☐Cancer ☐Diabetes ☐Other: ________ ☐Other: ________
Father's side ☐Arthritis ☐Cancer ☐Diabetes ☐Other: ________ ☐Other: ________ ☐Other: ________
Mother's side ☐Arthritis ☐Cancer ☐Diabetes ☐Other: ________ ☐Other: ________ ☐Other: ________

PATIENT NAME: DATE:

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS	EAR/NOSE/THROAT	RESPIRATORY
_ Convulsions _ Dizziness _ Fainting _ Headache _ Nervousness _ Numbness _ Wheezing **MUSCLES & JOINTS** _ Low Back Problems _ Pain between Shoulders _ Neck Problems _ Arm Problems _ Leg Problems _ Swollen Joints _ Painful Joints _ Stiff Joints _ Sore Muscles _ Weak Muscles _ Walking Problems _ Sprains/Strains _ Broken Bones _ Scoliosis **CARDIO-VASCULAR** _ High Blood Pressure _ Heart Attack _ Pain over Heart _ Poor Circulation _ Heart Trouble _ Rapid Heart _ Slow Heart _ Strokes _ Swelling Ankles _ Varicose Veins	_ Earache _ Ear Noises _ Enlarged Thyroid _ Frequent Colds _ Hay Fever _ Nasal Blockage _ Nose Bleeds _ Pain behind Eyes _ Poor Vision _ Sinusitis _ Sore Throats _ Tonsillitis **GASTRO-INTESTINAL** _ Belching/Gas _ Colon Problems _ Constipation _ Diarrhea _ Excessive Hunger _ Excessive Thirst _ Gall Bladder Trouble _ Hemorrhoids _ Liver/Gallbladder _ Nausea _ Abdominal Pain _ Ulcer _ Poor Appetite _ Poor Digestion _ Vomiting _ Vomiting Blood _ Black Stool _ Bloody Stool _ Weight Loss/Gain **ENDOCRINOLOGY** _ Diabetic	_ Asthma _ Chronic Cough _ Difficulty Breathing _ Spitting Blood _ Spitting Phlegm **GENITO-URINARY** _ Blood in Urine _ Frequent Urination _ Kidney Infection _ Painful Urination _ Prostate Problems _ Loss of Bladder Control **SKIN OR ALLERGIES** _ Boils _ Bruising Easily _ Dryness _ Eczema/Rash/Dermatitis _ Hives _ Itching _ Sensitive Skin _ Allergy **FOR WOMEN ONLY** _ Birth Control _ Hormone Replacement _ Cramps/Backaches _ Excessive Flow _ Hot Flashes _ Irregular Cycle _ Miscarriage _ Painful Periods _ Vaginal Discharge _ Breast Pain _ Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation (PATIENT NAME): ___________________________________

Patient Signature: ____ Date: ____/_____/_____

INFORMED CONSENT

Please read and put your Initials in the area provided

_____ It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and medicine. Chiropractors believe that when they remove the interference to the nervous system (by way of a spinal adjustment), so that the spine is in correct alignment, *Innate Intelligence* can then act (by way of the nervous system), to heal diseases within the body to seek and restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its innate recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

_____ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, and diagnostic X-rays on me (or the patient named below, for whom I am legally responsible) by Dr. Kian Javid or any staff at South Bay Wellness Center.

_____ I understand and am informed that, the practice of chiropractic may have some risk, just like risk involved with any other activities we have in our lives. Including examination and treatment, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain and In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury.

The doctor, of course, will not give a chiropractic adjustment or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the doctor of chiropractic.

_____ I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known is in my best interest.

_____ I do further acknowledge that no guarantees or assurances have been made concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

_____ I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I have read, or have had read to me, the above consent I have also had an opportunity to ask questions.
All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition and for any future condition(s) for which I may seek treatment.

I agree to allow this office to examine me for further evaluation (PATIENT NAME): ____

Patient Signature: ____ **Date**: ____/_____/_____

Our Privacy Policy

South Bay Wellness Center is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship.

_____ I hereby authorize that my records of evaluation and treatment with South Bay Wellness Center, may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

I hereby authorize this office to release any information requested by my insurance Company to document my claim for benefits.

Patient Signature: ____ **Date**: ____/_____/_____

Financial Policy, Patient Bill of Rights and Responsibilities

Thank you for choosing South Bay Wellness Center as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. You are financially responsible for the full amount of services rendered when rendered. All patients must read and sign this form prior to receiving services. As a courtesy we can bill your healthcare insurance if you have Chiropractic benefits. It is your responsibility to provide us with your most current insurance information if you would like us to bill.

1. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

2. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim.

3. Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

4. In some cases before receiving services, you should verify if we are a participating provider for your insurance company. It is also necessary that if you are a participant in an HMO plan you must obtain an insurance referral from your primary care physician listed on your insurance card before you are seen by another healthcare provider.

5. In some cases co-payments and/or co insurance must/may be collected at the time of service. This is a requirement set by your insurance company. No exceptions.

6. You must provide your most current billing address, all available telephone numbers and any other important contact information, and if any of this changes, it is your responsibility to contact us with the updated information.

7. Interest and/or finance fees may be added to any outstanding balance not paid within 20 days of receipt of the first statement.

8. Personal Injury or Automobile Accidents: It is our office policy to allow 90 days after you have been dismissed from care for the claim to be settled with the liability company. Once the 90 days is reached, if no settlement has been made, we require the patient to start making payments towards their personal injury case.

By signing below I acknowledge that I have read, or have had read to me the Financial Policy, Patient Bill of Rights and Responsibilities and also had an opportunity to ask questions and fully understand its terms. All of my questions have been answered to my satisfaction. By signing below, I understand that: I am personally responsible for full payment of all charges for my treatment. Services are payable at the time services are rendered. I am responsible to update my information if there is/are any change(s)

PATIENT/GUARDIAN NAME:

Patient Signature: ____ **Date**: ____/ /

Activities of Daily Living

Activities of Daily Living Scale #1 Use the following 1 to 5 Scale to describe the difficulties below, down through Travelling.	1 - "I can do it without any difficulty." 2 - "I can do it without much difficulty, despite some pain." 3 - "I manage to do it by myself, despite marked pain." 4 - "I manage to do it, despite the pain, but only if I have help. 5 - "I cannot do it at all, because of the pain."

Difficulties with Self Care and Personal Hygiene Activities:

Bathing ☐ Drying hair ☐ Brushing teeth ☐ Putting on shoes ☐ Preparing meals ☐ Taking out trash ☐ Showering ☐ Combing hair ☐ Making bed ☐

Tying shoes ☐ Eating ☐ Doing laundry ☐ Washing hair ☐ Washing face ☐ Putting on a shirt ☐ Putting on pants ☐ Cleaning dishes ☐ Going to the toilet ☐

Difficulties with Physical Activities:

Standing ☐ Walking ☐ Kneeling ☐ Bending back ☐ Twisting left ☐ Leaning back ☐ Sitting ☐ Stooping ☐ Reaching ☐

Bending left ☐ Twisting right ☐ Leaning left ☐ Reclining ☐ Squatting ☐ Bending forward ☐ Bending right ☐ Leaning forward ☐ Leaning right ☐

Standing for long periods ☐ Sitting for long periods ☐ Walking for long periods ☐ Kneeling for long periods ☐

Difficulties with Functional Activities:

Carrying small objects ☐ Lifting weights off floor ☐ Pushing things while seated ☐ Exercising upper body ☐ Carrying large objects ☐ Lifting weights off table ☐

Pushing things while standing ☐ Exercising lower body ☐ Carrying brief case ☐ Climbing stairs ☐ Pulling things while seated ☐ Exercising arms ☐

Carrying large purse ☐ Climbing inclines ☐ Pulling things while standing ☐ Exercising legs ☐

Difficulties with Social and Recreational Activities:

Bowling ☐ Jogging ☐ Swimming ☐ Ice skating ☐ Competitive sports ☐ Dating ☐ Golfing ☐ Dancing ☐ Skiing ☐ Roller skating ☐ Hobbies ☐

Dining out ☐

Difficulties with Travelling:

Driving a motor vehicle ☐ As a passenger in a motor vehicle ☐ As a passenger on a train ☐ Driving for long periods of time ☐ As airplane passenger ☐

Activities of Daily Living Scale #2 following 1 to 5 Scale to describe difficulties below	1 - "This area is not affected by my condition." 2 - "This area is slightly affected by my condition." 3 - "My condition moderately restricts my ability in this area." 4 - "My condition seriously limits my ability in this area." 5 - "My condition prevents me from using this ability."

Difficulties with Different Forms of Communication:

Concentrating ☐ Hearing ☐ Listening ☐ Speaking ☐ Reading ☐ Writing ☐ Using a keyboard ☐

Difficulties with the Senses:

Seeing ☐ Hearing ☐ Touch ☐ Taste ☐ Sense of Smell ☐

Difficulties with Hand Functions:

Grasping ☐ Holding ☐ Pinching ☐ Percussive movement's ☐ Sensory discrimination ☐

Difficulties with Sleep and Sexual Activity:

Being able to have a normal, restful night's sleep ☐

Being able to participate in desired sexual activity ☐

Additional Activities of Daily Living Information:

Patient Signature: ______________________________ **Date:** ______________________

9/26/20