

Wells Chiropractic Corporation
5363 Balboa Blvd., #234 Encino, CA 91316 818-788-4220

Welcome to our office. Please take a few moments to complete these forms. We will not release any of your confidential health information to a third party without your written or verbal consent. We look forward to helping you reach your treatment goals.

Patient Name _____

Street Address _____

City _____ State _____ ZIP _____ Email address _____

Birthdate _____ Age _____ Gender _____ Male/Female

Home phone _____ Work phone _____ Cell _____

Occupation _____ Full-time student _____

Employer _____

Marital Status: S/M/D/W _____ Spouse name _____ # children _____

Emergency Contact Name _____ Relationship _____ Phone # _____

Referred by: _____

Reason for visit Injury at work Auto accident Other injury Date of injury _____

Illness Wellness care Consultation

Financial Policies

We expect payment at the time services are rendered. We do not accept Worker's Compensation, automobile, group health insurance, attorney liens, MediCal or third party auto insurance. We accept cash, check or credit cards. We do not belong to any HMO or PPO insurance plans. If you want to know what your carrier will cover, ask them about "out of network" coverage. Let us know if you are submitting a claim for reimbursement and we will provide you with a receipt which can be attached to your carrier's claim form. As we don't know the particulars of your policy, we cannot guarantee payment by your carrier for our services.

Do you intend to bill your insurance carrier? Yes/No

Please note that a \$40 charge will be made for appointments cancelled with less than 24 hours notice. Insurance will not reimburse this charge.

Medicare Beneficiaries only

Medicare will not pay for services provided by this office as Dr Wells is a non-participating Medicare provider. You may submit your receipt to Medicare and ask that they provide you a denial letter in order to bill your secondary insurance. Manual Manipulation of the spine will be charged at a reduced rate for Medicare eligible individuals.

Payment is expected at the time services are rendered

By signing below, I acknowledge that all services provided to me are charged directly to me and that I am personally responsible for payment at the time services are rendered.

Patient Signature _____

Date _____

Name and signature of parent/legal guardian or person who is financially responsible

Date _____

Patient name _____

Date _____

Conditions	Severity	Frequency
Please list your reason(s) for coming (health conditions) in the order of importance.	Rate pain or symptoms from "0" none to "10" severe NoneSevere	Please check the box that best represents the amount of time you feel your pain or symptoms
1	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
2	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
3	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
4	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%

Describe below

For each condition listed above, please mark how it happened:

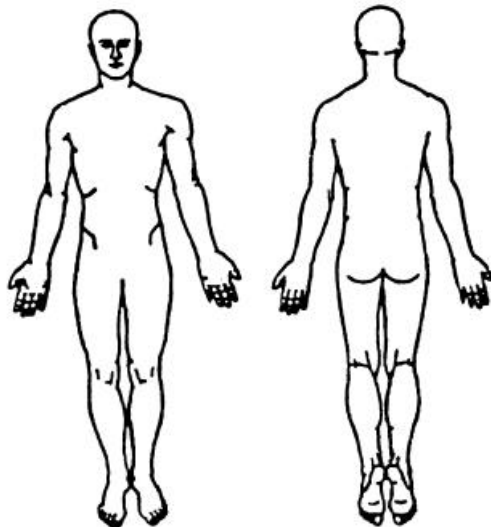
1	Injury <input type="checkbox"/>	Dated <input type="checkbox"/>	Illness <input type="checkbox"/>	Gradual onset <input type="checkbox"/>	Don't know <input type="checkbox"/>	
2	Injury <input type="checkbox"/>	Dated <input type="checkbox"/>	Illness <input type="checkbox"/>	Gradual onset <input type="checkbox"/>	Don't know <input type="checkbox"/>	
3	Injury <input type="checkbox"/>	Dated <input type="checkbox"/>	Illness <input type="checkbox"/>	Gradual onset <input type="checkbox"/>	Don't know <input type="checkbox"/>	
4	Injury <input type="checkbox"/>	Dated <input type="checkbox"/>	Illness <input type="checkbox"/>	Gradual onset <input type="checkbox"/>	Don't know <input type="checkbox"/>	

For each reason or condition listed above, please check if it is better or worse with any of the following:

	Heat		Cold		Rest		Activity		Other		Please Describe
	Better	Worse	Better	Worse	Better	Worse	Better	Worse	Better	Worse	
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please mark areas of pain or abnormal sensation on the figures below using the symbol that best describes the feeling:

+++ = sharp pain
ooo = Pins/needles
vvvv = dull ache
/// = numbness



Activity	Normal	Limited	Unable
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer/typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During what time of day do you feel better? _____ Worse? _____

Do you sleep well? _____ What are your normal sleeping hours? From _____ To _____

Patient name _____

Date _____

Are you currently under the care of a medical doctor or other health care provider for any condition?

If yes, for what condition? _____

Name of provider _____

Phone number _____

Please list any medications you are taking, the dosage, reason for taking and the date you started.

Medication	Dosage	Reason	Date started

Allergies Please list any allergies _____**Hospitalizations** Have you ever had a surgical procedure of any kind or an overnight stay in a hospital? _____

If yes, Please describe each event below: _____

Event _____ Year _____

Event _____ Year _____

Please check the boxes which best describe your digestion: Good Indigestion Constipation
Diarhea/soft stools Lack of appetite Cravings (describe) _____**For women only**

Are you currently pregnant? Y/N _____ Number of pregnancies _____ Number of births _____

What age did menses begin? _____ If menopausal, what age did you stop? _____

Is your period regular? Irregular? How many days is your usual cycle? _____

Date last period started? _____ How many days does your bleeding last? _____

Please check the box below that best describes your discharge:

Scant, thin, pale red Normal red flow Heavy, dark, clotted

How do you feel before your period? _____

How do you feel after your period? _____

Personal History Please read each whole symptom description before checking the boxes that apply.

Pain in body	Current conditions	Previously diagnosed conditions
<input type="checkbox"/> Neck pain with difficulty swallowing	<input type="checkbox"/> Recent progressive muscle weakness/shaking	<input type="checkbox"/> Severe degenerative arthritis
<input type="checkbox"/> Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck	<input type="checkbox"/> Recent or current fever over 102 degrees	<input type="checkbox"/> Rheumatoid or psoriatic arthritis
<input type="checkbox"/> Leg pain that worsens with exercise but is relieved by rest	<input type="checkbox"/> Loss of bowel or bladder control	<input type="checkbox"/> Compression fracture or severe osteoporosis
<input type="checkbox"/> Loss of feeling in inner thighs	<input type="checkbox"/> Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions	<input type="checkbox"/> Previous or current diagnosis of cancer
<input type="checkbox"/> Back pain together with urinary problems	<input type="checkbox"/> Recent, unexplained weight loss	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Loss of balance or coordination	<input type="checkbox"/> Immune suppression from chemo or organ transplant
	<input type="checkbox"/> Memory loss after injury	<input type="checkbox"/> Gout
	<input type="checkbox"/> Recent major accident such a fall, blow to head or whiplash	<input type="checkbox"/> Lupus
		<input type="checkbox"/> 3 or more months of steroid or IV drug use
		<input type="checkbox"/> HIV/AIDS

Family History	Autoimmune diseases	Cancer	Heart disease	Mental illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you for taking the time to provide us with this information. We look forward to serving you.

Informed Consent to Treatment

I hereby request and consent to the performance of non-force chiropractic, acupuncture and related procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Dr. David E. Wells, D.C., L.Ac. and /or other health professionals who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. David E. Wells, D.C., L.Ac.

I understand that methods or treatment may include, but are not limited to, chiropractic, acupuncture, moxibustion, ultrasound, massage, hot or cold packs, traction, Chinese or Western herbal medicine, and nutritional/lifestyle counseling.

I have the opportunity to discuss with Dr. Wells and/or other office personnel the nature and purpose of chiropractic or acupuncture treatment and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been rare instances reported in the literature of fainting, infections, scarring, spontaneous abortions, and pneumothorax. Dr. Wells uses pre-sterilized, disposable needles exclusively in his practice.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I become pregnant, I will inform Dr. Wells. If I experience any gastro-intestinal upset or allergic reactions to the herbs/nutritional supplements I will inform Dr. Wells.

I do not expect Dr. Wells to be able to anticipate and explain all possible risks and complications. I wish to rely on him to exercise good judgment and to provide treatment regarding my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my prior written consent. I further understand that after the first visit, treatment usually takes place in an open room. If at time I wish to discuss anything in private or want privacy for any reason, I may request one of the private rooms. I also understand that the complete office privacy policy is available to me at my request.

In the event of a dispute regarding possible malpractice, I agree to use binding arbitration rather than the courts.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below I agree to the above-named procedures. 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.

Signed _____ Date _____

Patient's Name _____ (please print)

Signature of Parent or Legal Guardian _____

Relationship to patient _____