5444 Shenandoah Ave.
Los Angeles, CA 90056
310.975.4888

Name: ____________________ Today's Date: ____ / ____ / _____

Date of Birth: ____ / ____ / _____ Age: ____ Height: _____ Weight: _____

Address: ____________________ City: ____________ State: _______ Zip: ________

E-mail: ____________________ Phone # ____________________

Name you prefer to be called? ____________________

Employer's Name ____________________ Your Occupation ____________________

Whom may we contact in case of emergency? ____________________

Home # ____________ Work # ____________ Cell # ____________

Are you currently seeing any other health care professionals? ○ Yes ○ No

Who? ____________________

Why? ____________________

Have you ever been to a chiropractor before? ○ Yes ○ No

Have you ever been told you have any issues related to your spine or nervous system? ○ Yes ○ No

If yes, what? ____________________

What is your overall stress level? ○ Mild ○ Moderate ○ Severe ○ Extreme

STRESS HISTORY

Stresses that may negatively affect your spine and nervous system can be **PHYSICAL, CHEMICAL,** or **MENTAL/EMOTIONAL** in nature and may begin at **birth.**

1. Were there any problems with your mother's pregnancy with you? ○ Yes ○ No
2. Your birth can be best described as: ○ Normal/ No complications

○ C-section ○ Cord around neck ○ Drug induced

○ Premature ○ Traumatic ○ Breech

○ Forceps or suction ○ Other: ____________________

PHYSICAL STRESS

1. Have you ever sustained a direct injury to your head, neck, or spine? ○ Yes ○ No
2. Have you ever experienced a loss of consciousness due to physical trauma? ○ Yes ○ No
   If yes, describe ______
3. Were you involved in any major accidents from chilhood to the present? ○ Yes ○ No
   If yes, describe ______
4. Are you now (or were you previously) active in any sport(s)? ○ Yes ○ No
5. Were you ever injured playing any of these sports? ○ Yes ○ No
   If yes, describe ______
6. List **ALL** surgeries and invasive medical procedures**:** ______

CHEMICAL STRESS

1. List all **current** medications: ______
2. Have you ever taken any drugs or medications on a regular basis **in the past**? ○ Yes ○ No
   If yes, what? ______
3. Have you ever worked with or been exposed to any chemicals, fumes, powders, or smoke (including tobacco, cannabis) for prolonged periods of time? ○ Yes ○ No
   If yes, describe ______
4. Alcohol consumption? ○ Never ○ Monthly or less ○ 1-2 x's/week ○ 3 or more x's/week
5. Do you consume: ○ artificial sweeteners ○ Tap Water ○ Nutritional Supplements

MENTAL & EMOTIONAL STRESS

- Check the level of **severity** of each **stressor** that applies to you:

	Mild	Moderate	Severe
Childhood	☐	☐	☐
Family	☐	☐	☐
Parent's divorce	☐	☐	☐
Personal relationship	☐	☐	☐
Divorce/Separation	☐	☐	☐
Work/School	☐	☐	☐
Financial	☐	☐	☐
Loss of loved ones/pets	☐	☐	☐
Stress of illness/ injury	☐	☐	☐
Abuse	☐	☐	☐
Moving	☐	☐	☐

REVIEW OF SYSTEMS (NEUROLOGICAL ZONES)

INSTRUCTIONS: Read each symptom and **number it** based on the level of **severity:**

1	For **MILD** symptoms or symptoms that rarely occur
2	For **MODERATE** symptoms or symptoms that occur frequently
3	For **SEVERE** symptoms or symptoms that are constantly present
	If symptom **DOES NOT APPLY** to you, then leave it **BLANK.**

	GLANDULAR (ZONE 1)
	Excessive perspiration
	Unable to concentrate
	Insomnia
	Sensitive/Dry or Scaly Skin
	Quick To Anger/Loses Temper
	Wake up tired
	Swollen lymph nodes
	Poor memory
	Fatigue easily
	FEMALES: Irregular menstrual cycle

	ELIMINATIVE (ZONE 2)
	Poor complexion/acne or Blemishes
	Difficulty breathing/lung issues
	Urinary difficulty/infections
	Constipation or diarrhea
	Cough--dry or Productive(mucus)
	Clears throat often/sore throat
	Excessive Foot/body odor
	Post nasal drip/sinus infection
	Frequent colds/Flu
	Skin irritation or itching

	NERVOUS SYSTEM (ZONE 3)
	Headaches
	Ringing in ears (tinnitus)
	Pain in neck/Face/Head
	Vision problem(s)
	Dizziness/Vertigo
	Obsessive/Compulsive
	Restless leg syndrome
	Jaw clenching/teeth grinding
	Lack of sensation/numbness
	Anxiety

	DIGESTION (ZONE 4)
	Bad breath
	Nausea/Vomiting
	Bloating after meals
	Indigestion/Heartburn/Reflux
	Brownish (Liver)Spots on skin
	Food Allergy/Sensitivity/Intolerance
	Stomach ache
	Bad taste in mouth
	Swollen or Coated Tongue
	Persistent pain between shoulder blades

	MUSCULAR (ZONE 5)
	Painful or Swollen Joints
	Muscle soreness (for no reason)
	Deep pain or ache in neck/shoulders/arms
	Deep pain or ache in back/legs/feet
	Muscle twitching/spasm/cramping
	Pain/pressure in head
	Weakness in upper/lower limbs
	Stiff Joints/Tight Muscles
	Tremors or uncontrollable shaking
	FEMALES: Menstrual cramping

	CIRCULATORY (ZONE 6)
	High blood pressure
	Low blood pressure
	Heart palpitations
	Chest pain/pressure
	Irregular heartbeat
	Swelling in both ankles or both feet
	Cold feet/hands
	Varicose Veins
	Bruises easily
	FEMALES: Irregular Menstrual Flow

NOTICE OF PRIVATE PRACTICES ACKNOWLEDGMENT FORM

*This notice describes how medical information about you may be used and disclosed. **Please review it carefully**. This office is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.*

We will never share your personal or private information with others.

We may only disclose information about you in the following ways:

- **To another health-care provider, hospital or facility if they request it in order to assist them in caring for you.**
- **To an insurance carrier or employer if they are possibly responsible for payment or reimbursement of services.**
- **If you are not available to receive an appointment reminder, a message may be left on your answering machine or with a person in your household or at work. We may also send you correspondence by e-mail.**

My signature acknowledges I have read this notice, understand it and agree with the policies explained. By way of my signature, I provide this office with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described above.

Signed ____ Date ____ / ____ / ____

CONSULTATION NOTES

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