

INITIAL HEALTH STATUS

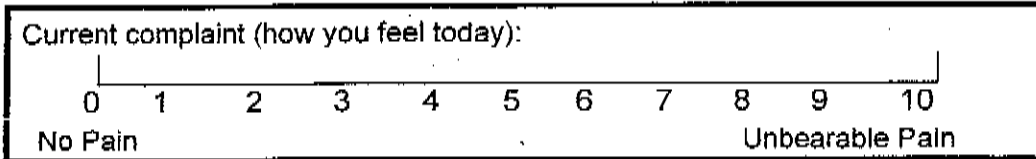
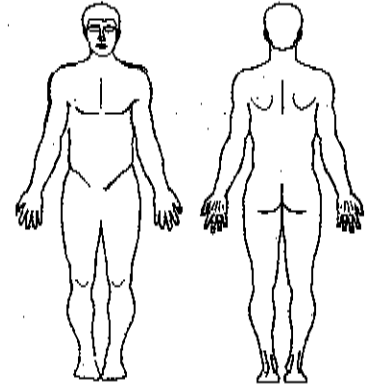
Patient Name: _____ Birthdate: _____ Sex: M / F
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone: _____ Social Security #: _____ Driver Lic. #: _____
 Occupation: _____ Employer: _____ Work Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Subscriber Name: _____ Health Plan: _____
 Subscriber ID #: _____ Group #: _____ Spouse Name: _____
 Spouse Employer: _____ City: _____ State: _____ Zip: _____
 Primary Care Physician Name: _____ PCP Phone: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Is this? Work Related Auto Related N/A

DATE PROBLEM BEGAN: _____



How often are your symptoms present? 0 - 25% 26 - 50% 51 - 75% 76 - 100%
 Can you perform your daily activities? Yes No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: None Apply

- | No | Yes | Condition |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma |

- | No | Yes | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____ |

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature: _____ Date: _____

INFORMED CONSENT FOR MASSAGE THERAPY

I hereby request and consent to the performance of therapeutic massage on me (or on the patient named below, for whom I am legally responsible) by the staff at Tustin Family Chiropractic.

I understand that in the practice of massage therapy there are extremely slight risks to treatment, including but not limited to fractures, dislocations and strains. I do not expect the licensed therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the licensed massage therapist to exercise judgment during the course of the procedure which he/she 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-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.

Patient's name (please print) _____ Date _____

Signature of patient _____

INFORMED CONSENT FOR CHIROPRACTIC CARE OF A MINOR

Name of Responsible Party _____ Social Security Number _____

Relationship to Minor _____

Address or Responsible Party _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Responsible Party Employed By _____

Employers Address _____ City _____ State _____ Zip _____

I (We) being the parent or guardian of _____, a minor, the age of _____ do hereby consent, authorize and request Tustin Family Chiropractic licensed massage therapist to administer such treatment deemed advisable, necessary or requested on the above minor.

I (We) agree to hold him/her free and harmless from any claims or suits for damages or complications, which may result from such treatment.

Signature of parent or guardian _____ Date _____

Signature of witness _____ Date _____

INFORMED CONSENT FOR CHIROPRACTIC 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 staff at Tustin Family Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic there are extremely slight 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, 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 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-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.

Patient's name (please print) _____ **Date** _____

Signature of patient _____

INFORMED CONSENT FOR CHIROPRACTIC CARE OF A MINOR

Name of Responsible Party _____ Social Security Number _____

Relationship to Minor _____

Address or Responsible Party _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Responsible Party Employed By _____

Employers Address _____ City _____ State _____ Zip _____

I (We) being the parent or guardian of _____, a minor, the age of _____ do hereby consent, authorize and request Tustin Family Chiropractic doctors to administer such treatment deemed advisable, necessary or requested on the above minor.

I (We) agree to hold him/her free and harmless from any claims or suits for damages or complications, which may result from such treatment.

Signature of parent or guardian _____ **Date** _____

Signature of witness _____ **Date** _____