Date:_____

Welcome to Our Office!

1400 Guerneville Rd. Suite 4, Santa Rosa, CA 95403

Last_____ **First**_____ **Middle Initial**___ **Birth Date**_____ **Age**_____

Address_____ **City** _____ **ST**_____ **Zip**_____

Phone (H) _____ **(C)**_____ **Email**_____

Occupation_____

Have you had previous Chiropractic care? □yes □no **Positive Experience:** □yes □no

Who is your primary care physician?_____ **Phone**_____ **Date of Last Exam**_____

WHAT BRINGS YOU TO OUR OFFICE? **Please provide as much detail as possible.**

Current Complaint: _____

_____**Date symptoms first appeared**_____

How did it begin:_____

How often do you experience the symptoms? □ Constant □ Frequent □ Intermittent □ Occasional □ Rare

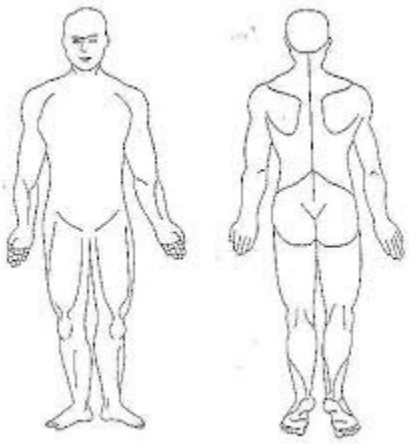
Have you ever experienced the same or similar symptoms? □yes □no **When?**_____

Have you been to another doctor for this problem? □yes □no **Who/Where**_____

Type of Pain: □Sharp □Dull □Ache □Burn □Throb □Other **Numbness or Tingling?** □yes □no **Where?**_____

Does the pain Radiate into: □Arm □Hand □Leg □Foot □Other_____ □Doesn't Radiate

What makes symptoms increase? _____**What relieves symptoms**_____



Please mark off all areas of complaint on the diagrams with the following indicators:

A=ache D=dull

N=NumbnessT=Tingling B=Burning

S=Sharp/Stabbing O=Other

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme).

Have you ever been in an auto accident? □Past Year □Past five years □over 5 years □Never

Please describe:_____

Please List ALL surgeries, injuries, accidents, falls, etc:_____

_____

List all Medications/Supplements_____

Do you smoke? □yes □no **If yes, how many packs/wk?** ____ **Have you ever smoked in the past?** □yes □no **When did you quit?**_____

Do you consume alcohol? □yes □no **Do you consume cafine?** □yes □no

Do you exercise? □yes □no **If yes, how many times per week and what type?**_____

Do you have a high stress level? □yes □no **If yes, list reasons**_____

Is there any possibility that you may be pregnant? □yes □no

Health History – Please circle all that apply

AIDS/ HIV	**Allergy Shots**	**Anemia**	**Anorexia**	**Appendicitis**	**Arthritis**	**Asthma**	**Bleeding**
Breast Lump	**Bronchitis**	**Bulimia**	**Cancer**	**Cataracts**	**Chicken pox**	**Depression**	**Diabetes**
Emphysema	**Epilepsy**	**Fractures**	**Glaucoma**	**Goiter**	**Gout**	**Heart dx**	**Hepatitis**
Hernia	**Herniated disc**	**High Cholest**	**Kidney dx**	**Liver dx**	**Measles**	**Migraines**	**Mono**
M. S.	**Mumps**	**Osteoporosis**	**Parkinson's**	**Polio**	**Pacemaker**	**Pneumonia**	**Prostate**
Prosthesis	**Implants**	**Rheumatoid**	**Stroke**	**Thyroid**	**Tonsillitis**	**Tuberculosis**	**Tumors**
Typhoid	**Ulcers**	**Chronic Fatigue**		**High Blood Pressure**		**Fibromyalgia**	

Other_____

Family History – List any diseases and conditions that are current health problems of family members.

_____

_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some 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 upon the facts then known, is in my best interest. I further understand that there are treatment options available for my condition other than chiropractic procedures. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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. Initial_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law. Initial_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that True Upper Cervical HealthCare will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to True Upper Cervical HealthCare, and Dr. Set Terzian, DC. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____Date: _____

Guardian's Signature: _____Date: _____