CASE HISTORY

Name: ____ Age: ____ Date: ____ Case Number: ____
Address: ____ City: ____ State: ____ Zip: ____
Phone(Home): ____ Date of Birth: ____ Sex: ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W # Children: ____
Occupation: ____ Employer: ____ Telephone (Work): ____ Ext.# ____
Insured's Name: ____ Phone: ____ Insured's Date of Birth: ____
Spouse's Name: ____ Spouse's Occupation: ____
Spouse's Employer: ____ Spouse's Telephone (Work): ____
Referred by: ____ Past Chiropractic Care: ☐ Yes ☐ No When? ____
Doctor's Name: ____ Results: ____
Insurance Company: ____ Telephone: ____
Social Security Number: ____ Driver's License Number: ____ State: ____
Spouse's Insurance Company: ____ Telephone: ____
Spouse's Social Security Number: ____ Spouse's Driver's License Number: ____

Chief Complaint: 1. ____ Duration-(How Long): ____ Previous Episodes: ____
List Current 2. ____ Duration-(How Long): ____ Previous Episodes: ____
Problems 3. ____ Duration-(How Long): ____ Previous Episodes: ____

Are your present problems due to an injury? ☐ No ☐ Yes ☐ On Job ☐ Auto Accident ☐ Personal Injury ☐ Other: ____
Has the accident been reported? ☐ No ☐ Yes ☐ To Employer ☐ Auto Carrier ☐ Other: ____
Are you now or have you ever been disabled? (Service or Work)? ☐ No ☐ Yes When? ____
Have you retained an attorney? ☐ No ☐ Yes Name & Address: ____

Please mark the intensity of your pain today.

1 - NO PAIN
10 - MOST INTENSE EVER FELT

Example Neck
1 2 3 ❹ 5 6 7 8 9 10

1. ____
1 2 3 4 5 6 7 8 9 10

2. ____
1 2 3 4 5 6 7 8 9 10

3. ____
1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness P-Pain
T-Tingling A-Ache
S-Soreness ST-Stiffness

Left Left

DOCTOR USE ONLY

____
____
____
____

HABITS

☐ Smoking Packs/Day: ____
☐ Drinking Alcohol: ____
☐ Coffee Cups/Day: ____

EXERCISE

☐ None
☐ Moderate
☐ Daily
Type: ____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, # of ____	☐	☐	☐	☐	☐
Sister, # of ____	☐	☐	☐	☐	☐

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐ 541 Appendicitis	☐ 280 Anemia	☐ 429.9 Heart Disease	☐ 716 Arthritis
☐ 480 Pneumonia	☐ 055 Measles	☐ 240 Goiter	☐ 345 Epilepsy
☐ 390 Rheumatic Fever	☐ 072 Mumps	☐ 487 Influenza	☐ 319 Mental Disorder
☐ 045 Polio	☐ 052 Chicken Pox	☐ 511 Pleurisy	☐ 724.2 Lumbago
☐ 011 Tuberculosis	☐ 250 Diabetes	☐ 305.0 Alcoholism	☐ 690 Eczema
☐ 033 Whooping Cough	☐ 239 Cancer	☐ 099 Venereal Disease	☐ 044 HIV Positive

(OVER)

Email ____

Please check the correct box for each below. Check at least one box for each sign or sympt sted. ☐ Never ☐ Previously ☐ Presently.

GENERAL SYMPTOMS

Never	Previously	Presently	Code	Symptom
☐	☐	☐	905.3	Allergy(What) ______
☐	☐	☐	491	Bronchitis
☐	☐	☐	780.9	Chills
☐	☐	☐	780.3	Convulsions
☐	☐	☐	780.4	Dizziness
☐	☐	☐	780.2	Fainting
☐	☐	☐	780.7	Fatigue
☐	☐	☐	780.6	Fever
☐	☐	☐	784.0	Headache
☐	☐	☐	780.52	Loss of Sleep
☐	☐	☐	783	Loss of weight
☐	☐	☐	799.2	Nervousness
☐	☐	☐	729.2	Neuralgia
☐	☐	☐	780.8	Night Sweats
☐	☐	☐	782	Numbness or pain in arms/legs/hands
☐	☐	☐	786.09	Wheezing

GASTRO-INTESTINAL

Never	Previously	Presently	Code	Symptom
☐	☐	☐	787.3	Belching or Gas
☐	☐	☐	789.0	Colon Trouble
☐	☐	☐	564.0	Constipation
☐	☐	☐	558.9	Diarrhea
☐	☐	☐	783.6	Excessive Hunger
☐	☐	☐	575.9	Gall Bladder Trouble
☐	☐	☐	455.6	Hemorrhoids (piles)
☐	☐	☐	782.4	Jaundice
☐	☐	☐	794.8	Liver Trouble
☐	☐	☐	787.0	Nausea
☐	☐	☐	536.8	Pain over Stomach
☐	☐	☐	783.0	Poor Appetite
☐	☐	☐	536.8	Poor Digestion
☐	☐	☐	787.0	Vomiting
☐	☐	☐	578.0	Vomiting Blood

EYE/EAR/NOSE/THROAT

Never	Previously	Presently	Code	Symptom
☐	☐	☐	493.9	Asthma
☐	☐	☐	378.9	Crossed Eyes
☐	☐	☐	389.9	Deafness
☐	☐	☐	388.70	Earache
☐	☐	☐	388.60	Ear Discharge
☐	☐	☐	388.30	Ear Noises
☐	☐	☐	240.9	Enlarged Thyroid
☐	☐	☐	460	Frequent Colds
☐	☐	☐	477.9	Hay Fever
☐	☐	☐	784.49	Hoarseness
☐	☐	☐	478.1	Nasal Obstruction
☐	☐	☐	784.7	Nose Bleeds
☐	☐	☐	379.91	Pain in Eyes
☐	☐	☐	368.9	Poor Vision
☐	☐	☐	473.9	Sinusits
☐	☐	☐	462	Sore Throats
☐	☐	☐	463	Tonsillitis

RESPIRATORY

Never	Previously	Presently	Code	Symptom
☐	☐	☐	786.50	Chest Pain
☐	☐	☐	786.2	Chronic Cough
☐	☐	☐	786.09	Difficulty Breathing
☐	☐	☐	786.3	Spitting Blood
☐	☐	☐	786.4	Spitting Phlegm

GENITO-URINARY

Never	Previously	Presently	Code	Symptom
☐	☐	☐	788.3	Bed Wetting
☐	☐	☐	599.7	Blood in Urine
☐	☐	☐	788.4	Frequent Urination
☐	☐	☐	788.3	Inability to Control Urine
☐	☐	☐	590.9	Kidney Infection
☐	☐	☐	788.1	Painful Urination
☐	☐	☐	601.9	Prostate Trouble

MUSCLES & JOINTS

Never	Previously	Presently	Code	Symptom
☐	☐	☐	724.5	Backache
☐	☐	☐	719.7	Foot Trouble
☐	☐	☐	550.0	Hernia
☐	☐	☐	719.1	Pain Between Shoulders
☐	☐	☐	724.6	Painful Tail Bone
☐	☐	☐	723.9	Stiff Neck
☐	☐	☐	781.9	Spinal Curvature
☐	☐	☐	719.0	Swollen Joints
☐	☐	☐	781.0	Tremors
☐	☐	☐	781.0	Twitching

CARDIO-VASCULAR

Never	Previously	Presently	Code	Symptom
☐	☐	☐	401.9	High Blood Pressure
☐	☐	☐	458.9	Low Blood Pressure
☐	☐	☐	786.51	Pain over Heart
☐	☐	☐	785.9	Poor Circulation
☐	☐	☐	438	Previous Heart Trouble
☐	☐	☐	785.0	Rapid Heart
☐	☐	☐	427.89	Slow Heart
☐	☐	☐	436	Strokes
☐	☐	☐	782.3	Swelling Ankles
☐	☐	☐	454	Varicose Veins

SKIN OR ALLERGIES

Never	Previously	Presently	Code	Symptom
☐	☐	☐	690	Boils
☐	☐	☐	924.9	Bruising Easily
☐	☐	☐	701.1	Dryness
☐	☐	☐	691.8	Eczema
☐	☐	☐	708.9	Hives or Allergy
☐	☐	☐	698.9	Itching
☐	☐	☐	782.0	Sensitive Skin
☐	☐	☐	368.9	Skin Eruptions

FOR WOMEN ONLY

Never	Previously	Presently	Code	Symptom
☐	☐	☐	625.3	Cramps or Backaches
☐	☐	☐	626.2	Excessive Flow
☐	☐	☐	627.2	Hot Flashes
☐	☐	☐	626.4	Irregular Cycle
☐	☐	☐	634.9	Miscarriage
☐	☐	☐	625.3	Painful Periods
☐	☐	☐	623.5	Vaginal Discharge

☐Yes ☐No Pregnant at this time

__________ Last Pap Date

__________ By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
______	Vaccinations	______	Tubes in Ears	______	Sinus
______	Tonsillectomy	______	Appendectomy	______	Hernia
______	Gall Bladder	______	Female Organs	______	Thyroid
______	Back Operation	______	Rectal Surgery	______	Stomach
______	Other: ______	______	Other: ______	______	Other: ______

☐ I have never had any operations / surgeries

List any accidents or falls and dates: ☐ Car: ______ ☐ Recreation Vehicle: ______

☐ Sports: ______ ☐ School: ______ ☐ Other: ______

List any broken bones(fractures) or dislocations: ______

Ever on crutches? ☐ Yes ☐ No Why? ______

Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No Were you ever knocked unconscious? ☐ Yes ☐ No

Have you ever had a lapse of memory? ☐ Yes ☐ No

Have you ever had X-rays taken? ☐ Yes ☐ No When? ______ By Whom? ______

For what ailments were these X-rays made? ______

Do you suffer from any condition other than that for which you are now consulting us? ______

Are you presently taking any medication - prescription or over-the-counter? ☐ No ☐ Yes What drugs? ______

What other factors of your health have you not revealed perhaps because you are embarrassed by them, if any? ______

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature: X ______ Date: ______

WAGNER CHIROPRACTIC
FINANCIAL & GENERAL OFFICE POLICY
Please read the following and initial were indicated below. Thank you.

___ The standard fee for a new patient for Dr. Wagner is $250, and for an established patient is $100 to $250 per treatment, depending on time spent. If you are in need of an adjustment to correct one specific problem, by prior arrangement, the fee may be reduced if your condition does not require a complete examination and treatment. Additional charges may apply depending upon the time and type of treatment given.

___ Dr. Wagner may recommend that you see another practitioner or use some equipment in this clinic. Please be aware that there is a separate fee for each practitioner who works with you and for the use of any machine. Those fees vary depending on the amount of time and type of treatment given. If you are concerned about your personal finances, please be sure to let the front desk know prior to your appointment.

___ Dr. Wagner may also recommend that you take particular supplements or homeopathics. Appropriate retail costs and sales tax applies for each product.

___ All Doctor/Practitioner services, merchandise and supplements shall be paid for at the time of your visit. We are not in a position to extend credit for services rendered or products sold.

___ Due to hypersensitivity of many of our patients, we request that you do not wear any perfume, cologne, or and other heavily scented product when you visit this office.

___ Your insurance is a contract between you and your insurance company. WAGNER CHIROPRACTIC does not participate with any insurance company nor does any medical billing for our patients. It is the responsibility of our patients to bill their insurance carrier for any reimbursement that may be allowed. Please be aware that not all services are covered (read your insurance policy for benefits). Some insurance companies arbitrarily select certain services they will not cover. We will provide you with a fee slip, which includes the appropriate codes and a diagnosis for submission to your insurance company.

___ Account balances more than 30 days overdue may be subject to additional collection fees and interest charges of 1.5% per month.

___ We do not take checks. Only cash or credit cards.

___ Cancellation Policy: We require 24 hours advance notice to avoid a cancellation fee.

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 on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I will have 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 other procedures. I understand that results are not guaranteed.

I 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, 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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.

Patient Signature ______________________________ **Date** ______________

Witness Signature ______________________________ **Date** ______________

WAGNER CHIROPRACTIC
17383 Sunset Blvd., #A 230
Pacific Palisades, CA 90272
(310) 230-2145

Informed Consent to Receive Treatment and Care

You are always welcome to ask for more details if you wish. Contraindications(symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and certain herbs include a history of bleeding disorder or current anticoagulation therapy, and implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy. It is important that you notify your practitioner if any of these apply to you.

_____ I understand that the diagnosis given to me conforms to the principles of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment.

I have provided a full history and description of the complaints and health status which is complete and accurate. I understand the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

_____ I understand that no guarantee has been made concerning the use and effects of Traditional Chinese Medicine (TCM). I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

_____ I understand that I may stop treatment at any time.

_____ I understand that while this document describes major risks of treatment, other side effects and risks may occur.

_____ **Acupuncture:** I understand that it is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur after treatment. Some very rare risks of acupuncture include spontaneous abortion, pneumothorax (air in the chest cavity that could cause a collapsed lung) and infection.

_____ **Moxibustion:** I understand that this is the application of indirect heat supplied by burning the herb Folium Artemesiae Vulgaris over a single acupuncture point or group of points. This generally produces a sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of moxibustion.

_____ **Cupping:** I understand that this is the application of round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration, and on rare occasions, a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injury.

_____ **Acupressure/Tui Na Massage:** I understand that I may be given acupressure massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am

aware that side effects that may result from this treatment include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

_____ Herbs and Nutritional Supplements: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiologic functions. Herbs are used to facilitate the body's own restorative process. The herbs are usually taken in tea form or mixing powdered granules. I understand that I am not required to take these substances but must follow the direction for administration and dosage if I do decide to take them.

_____ I understand that recommended herbs are traditionally considered safe in the practice of TCM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limted to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I will immediately notify my practitioner if any unanticipated or unpleasant effects associated with herb or supplement treatment.

_____ I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that my practitioner will exercise judgment during the course of treatment which they feel at the time, based on the facts known to them, is in the best interest of me as a patient.

_____ I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. I wish to proceed with TCM treatment. I understand that I am free to withdraw my consent to treatment at any time.

____

Patient Name:

____

Signature of Patient or person authorized to consent on behalf of the patient:

____

Date:

Date: ____________________

NAME: ____

REASON FOR TODAY'S VISIT

Please give a brief description of what you wish to work on today.

ADJUSTMENT ONLY (circle one):

1. Cervical 2. Lumbar 3. Lumbosacral 4. Ankle/Knee 5. Sacroiliac

6. Other (specify): ______________________________________

PHYSICAL:

____

____

____

DETOXIFICATION:

____

____

____

WEIGHT LOSS:

____

____

____

SPIRITUAL/EMOTIONAL:

____

____

____

OTHER:

____

____

____