# 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 ❸ 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

**DOCTOR USE ONLY**

_____

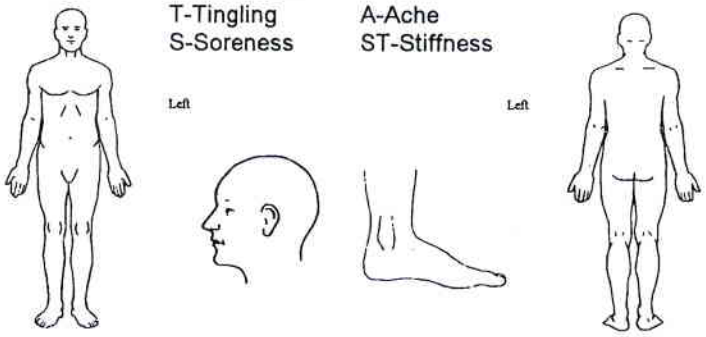
_____

_____

_____

**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




**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)

E-mail _____

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

| Never | Previously | Presently | GENERAL SYMPTOMS | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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 |

| Never | Previously | Presently | GASTRO-INTESTINAL | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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 |

| Never | Previously | Presently | EYE/EAR/NOSE/THROAT | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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 | Sinusitis |
| ☐ | ☐ | ☐ | 462 | Sore Throats |
| ☐ | ☐ | ☐ | 463 | Tonsillitis |

| Never | Previously | Presently | RESPIRATORY | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 786.50 | Chest Pain |
| ☐ | ☐ | ☐ | 786.2 | Chronic Cough |
| ☐ | ☐ | ☐ | 786.09 | Difficulty Breathing |
| ☐ | ☐ | ☐ | 786.3 | Spitting Blood |
| ☐ | ☐ | ☐ | 786.4 | Spitting Phlegm |

**GENITO-URINARY**

| | | | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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**

| | | | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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**

| | | | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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**

| | | | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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**

| | | | | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | 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 to Dr. Wagner is $200.00, and for an established patient is $75.00 to $150.00 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 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**

# ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist 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 understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

(Date)

PATIENT SIGNATURE X

(Or Patient Representative)

(Indicate relationship if signing for patient)

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:

_____

_____

_____