Dr. Steven Becker

WEST LA CHIROPRACTOR

NEW PATIENT DATA

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

SS#: _____ Date of birth: _____ Age: _____ Sex: _____

Height: _____ Weight: _____ Driver's license #: _____

Home phone: _____ Cell phone: _____

Email: _____ Occupation: _____

Work phone #: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip code: _____

Marital status: _____ Spouses name: _____ Contact in emergency: _____

Emergency phone number: _____ Relationship: _____

Medical insurance: ☐ Yes ☐ No Insurance co. name: _____

Name of insured: _____ ID #: _____ Group #: _____

Referred by (if applicable): _____

Regular physician: _____ City: _____

Specialty physician: _____ City: _____

Date of last physical: _____ Are you now pregnant: ☐ Yes ☐ No Date LMP: _____

Past surgeries: _____

Serious illnesses: _____

Current medications: _____

Prior chiropractic care: ☐ Yes ☐ No Doctor's name: _____

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NEW PATIENT DATA - CONTINUED

Purpose of this appointment: _____

Date symptoms appears/accident happened: _____

Ever had same or similar condition? ☐ Yes ☐ No Describe: _____

_____

Have you missed any days from work? ☐ Yes ☐ No

Is condition related to an injury from: ☐ Work ☐ Auto Accident ☐ Other

Patient ever had same or similar condition: ☐ Yes ☐ No If yes, when and describe: _____

_____

What activities aggravate your condition: _____

_____

Is this: ☐ Constant ☐ Intermittent ☐ Getting worse ☐ Improving slowly

Other doctors seen for this condition: _____

Have you been treated for any health conditions in the last year? _____

History of: ☐ Recent infection ☐ Recent Fever ☐ HIV/AIDS ☐ Stroke

Remarks and/or additional information: _____

_____

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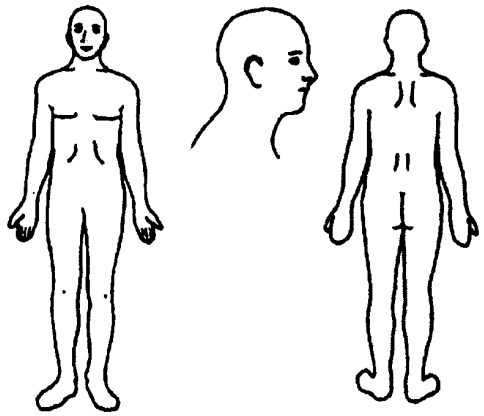
NEW PATIENT DATA - CONTINUED

Have you ever suffered from:

Past	Present		Past	Present		Past	Present	
		Corticosteroid use			Colitis or other Colon Problems			Alcoholism
		High blood pressure			Indigestion			Drug Addiction
		Dizziness/Vertigo			Constipation			Swelling of ankles
		Fainting			Diarrhea			Pain in feet
		Frequent Urination			Hemorrhoids			Knee problems
		Visual disturbances			Bruise easily			Leg pain or sciatica
		Cancer			Sinusitis/sinus infections			Scoliosis
		Diabetes			Depression			Arthritis, location in body:
		Kidney Disease			Panic attacks			Poor Posture
		Autoimmune Disease			Nausea	**Pain or stiffness in**		
		Heart attack			Asthma			Hip
		Aortic Aneurysm			Thyroid problems			Lower back
		Osteoporosis			Poor circulation			Middle back
		Prostrate Problems			Anemia			Neck
		Epilepsy or seizures			Ringing in ears			Shoulder
		Allergies			Chest pain	**Tingling or numbness in**		
		Fatigue			Difficulty breathing			Shoulder/arms
		Headaches			Hot flashes			Hands
		Migraine headaches			Menstrual Pain			Hip/legs
		Ulcers			Insomnia			Feet
		Abnormal weight gain/loss						Groin/Buttocks

Please mark your areas of pain on the figures below.



COMMENTS:

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment_____

I understand and agree that health and accident insurance policies are an arrangement between only my insurance carrier and myself. Furthermore, I understand that Dr. Becker will prepare any necessary reports and forms to assist me in making collections from my insurance company and that any amount authorized to be paid directly to his chiropractic office will be credited to my account upon 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 at the time the services are rendered.

Patient's Signature_____Date_____

Dr. Steven Becker

WEST LA CHIROPRACTOR

INFORMED CONSENT TO CHIROPRACTIC EXAMINATION TREATMENT

By signing this form, you are consenting to an examination by Dr. Becker and all health professionals associated with Dr. Becker. Although you do not have to submit to any or all examination procedures, we ask that you comply to the best of your ability and to report any changes in your pain. All procedures should be accomplished to your tolerance.

By signing this form, I also 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 of the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interests.

Therefore, by signing this form, I consent to the performance of chiropractic adjustments and other chiropractic procedures to my body, including various modes of physical therapy and diagnostic x-rays by Dr. Becker and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, or associated with Dr. Becker and accept the risks and consequences of their application.

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 my treatment for my present condition and for any future conditions for which I may seek treatment.

_____ _____

Signature Date