Dr. Todd B. Andrews DC,
1501 N. Placentia Ave.
Placentia, CA 92870
(714) 572-3834

Date_______________

PLEASE PRINT

PATIENT INFORMATION

Name______________________________________
Address____________________________________
City_____________________ Zip______________
Birth Date________________ Sex M F
Home Phone #_______________________________
Cellular Phone #_____________________________
Email Address_______________________________
Social Security # ____________________________
Marital Status_______________________________
Referred By_________________________________

EMPLOYER INFORMATION

Occupation__________________________________
Employer____________________________________
Employer Address_____________________________
City____________________ Zip_______________
Business Phone #_________________ext.________

REASON FOR CONSULTATION

What are your present complaints and symptoms?
____
____
Is your condition a result of a: Work injury?_______
Auto accident?_____
Other____________
Date of injury or onset_________________________
Family Physician_____________________________
Phone #____________________________________

RESPONSIBLE PARTY INFORMATION

(if other than self)
Name______________________________________
Relationship to Patient_____________________
DOB____________
Home Phone #______________________________
Cellular Phone #___________________________
Work Phone #______________________________
Address___________________________________
City____________________ Zip____________
Employer's Name__ _______________________
Address___________________________________
City____________________ Zip____________
Occupation________________________________
If patient is a child, name of other parent
____
Address___________________________________
City____________________ Zip____________
Home Phone #______________________________
Work #____________________________________

INSURANCE INFORMATION

Are you insured? Y N
(Please present insurance card to receptionist)
Insurance Company______________________
Other Insurance Company_________________

EMERGENCY CONTACT

Name______________________________________
Relationship_______________________________
Phone #____________________________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of benefits be made directly to this healthcare provider and I understand that I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Signed_______________________________________ Date_______________________________________
(Insured Person)

CONSENT TO TREATMENT OF A MINOR

I (we) being the parent or guardian of the above patient, a minor, the age of _______, do hereby consent, authorize and request this healthcare provider and whomever they may designate as their assistant, to administer such treatment deemed advisable, necessary or requested for this minor.

Signed_______________________________________ Date_______________________________________
(Parent or Legal Guardian)

JM04

Todd B Andrews, D.C.
1501 N. PLACENTIA AVE.
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CASH PAYMENT FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and assure you that you will be receiving the very best care available.

In order to familiarize you with the financial policies of our office, we would first like to explain how your medical bills will be handled.

It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time service is provided unless other arrangements are made with our business office.

After a period of ninety days, any unpaid balances will be considered past due and may be subject to a 1.5% per month interest charge. Our office policy is that a patient's balance not exceed $200.00. If it does exceed that amount, treatment may be suspended until the balance can be taken care of. If you need special arrangements, please see the business office.

It is also the policy of this office that if you should suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be due immediately and payable.

Once again, we would like to welcome you to our office. If you have any questions at this time, please feel free to ask.

I have read and agree to the above.

__________________________________ ________________________

Patient's Signature *Date*

Personal Health History

Name___________________________________ **Date:**____________________

INJURIES & ACCIDENTS:

Type of Accident — Date(s)

- ❒ Auto ____________________
- ❒ Work ____________________
- ❒ Fracture ____________________
- ❒ Dislocation ____________________
- ❒ Concussion ____________________
- ❒ Other ____________________

____

____

SURGERIES:

Type of Surgery

❒ Appendix ❒ Gall Bladder ❒ Hernia
❒ Hysterectomy ❒ Kidney ❒ Mastectomy
❒ Tonsils ❒ Other____________________

ILLNESS:

❒ AIDS ❒ Anemia ❒ Arthritis
❒ Asthma ❒ Blindness ❒ Bronchitis
❒ Cancer ❒ Cataracts ❒ Chicken Pox
❒ Cirrhosis ❒ Colitis ❒ Depression
❒ Diabetes ❒ Duodenal Ulcer ❒ Emphysema
❒ Enlarged Heart ❒ Epilepsy ❒ Gallstones
❒ Gastritis ❒ Glaucoma ❒ Goiter
❒ Gonorrhea ❒ Gout ❒ Hay Fever
❒ Heart Disease ❒ Hepatitis ❒ Hernia
❒ HIV ❒ Jaundice ❒ Malaria
❒ Kidney Stones ❒ Measles ❒ Mumps
❒ Mononucleosis ❒ Nephritis ❒ Paralysis
❒ Phlebitis ❒ Pleurisy ❒ Pneumonia
❒ Polio ❒ Psoriasis ❒ Scarlet Fever
❒ Syphilis ❒ Hyperthyroid ❒ Hypothyroid
❒ Low B.P. ❒ High B. P. ❒ High Triglycerides
❒ High Cholesterol ❒ Tuberculosis
❒ Rheumatic Fever
❒ Other ________________________
❒ Other ________________________
❒ Other ________________________

PSYCHIATRIC:

____

____

ALLERGIES:

❒ None ❒ Aspirin ❒ Cats
❒ Foods ❒ Codeine ❒ Dust
❒ Penicillin ❒ Pollen
❒ Other ____________________________________

HAVE YOU EVER BEEN DISABLED?

❒ Yes ❒ No Date(s) ___________________________

MEDICATION NOW TAKING: __________________

____

MARITAL STATUS:

❒ Single ❒ Married ❒ Separated
❒ Divorced ❒ Widowed

NUMBER OF CHILDREN:__________________________

EDUCATION:

Last grade level completed____________________________

FAMILY MEDICAL HISTORY:

Please identify illnesses within your immediate family

❒ Arthritis ❒ Cancer ❒ Diabetes
❒ Emphysema ❒ Epilepsy ❒ Hypertension
❒ Heart Disease ❒ Migraines ❒ Obesity
❒ Peptic Ulcer ❒ Renal Disease ❒ Rheumatic Fever
❒ Strokes ❒ Tuberculosis ❒ Rheumatoid Arthritis

Additional: ____

____

HOBBIES:

____

____

GENERAL INFORMATION:

Height: Feet_______ Inches________ Weight____________

Do you consider yourself…

❒ Alert ❒ Calm ❒ Nervous
❒ Irritable ❒ Depressed ❒ Fatigued
❒ Run Down

Do you suffer from loss of sleep? ❒ Yes ❒ No
Do you smoke or use tobacco? ❒ Yes ❒ No
Do you drink alcoholic beverages? ❒ Yes ❒ No
Do you drink caffeinated beverages? ❒ Yes ❒ No

Do you consider yourself…

❒ Well Developed ❒ Average Developed
❒ Under Developed ❒ Well Nourished
❒ Average Nourished ❒ Under Nourished
❒ Large Build ❒ Medium Build
❒ Small Build

WOMEN ONLY:

Are you pregnant at this time? ❒ Yes ❒ No
Date of last period ___________________________
Date of last breast exam _______________________
Date of last pap smear _________________________
Do you experience…

❒ Menstrual pain ❒ Cramping ❒ Irregularity

MEN ONLY:

Date of last prostate exam______________________________

____

PATIENT SIGNATURE

HISTORY OF SYMPTOMS

Name____________________

Date____________________

SYMPTOMS

HEAD:
- ❒ Headache
  - ❒ Entire head
  - ❒ Back of head
  - ❒ Forehead
  - ❒ Right temple
  - ❒ Left temple
  - ❒ Migraine
- ❒ Head feels heavy
- ❒ Loss of memory
- ❒ Light-headedness
- ❒ Fainting
- ❒ Light bother eyes
- ❒ Loss of balance
- ❒ Loss of smell
- ❒ Loss of taste
- ❒ Dizziness
- ❒ Loss of hearing
- ❒ Pain in ears
- ❒ Ringing in ears
- ❒ Buzzing in ears

NECK:
- ❒ Pain in neck
  Neck pain is worse when I:
  - ❒ bend forward ❒ bend left
  - ❒ bend backward ❒ bend right
  - ❒ turn right ❒ turn left
- ❒ Sensation of a pinched nerve
- ❒ Neck feels out of place
- ❒ Neck feels stiff
- ❒ Muscle spasms in neck
- ❒ Grinding or grating sounds in neck
- ❒ Popping sounds in the neck
- ❒ Arthritis in the neck

SHOULDERS:
- ❒ Pain in shoulder joint R L
- ❒ Pain across shoulders
- ❒ Bursitis R L
- ❒ Arthritis R L
- ❒ Can't raise arm:
  - ❒ above shoulder level
  - ❒ over head
- ❒ Tension in shoulders
- ❒ Pinched nerve in the shoulder R L
- ❒ Muscle spasms in shoulders

ARMS & HANDS
- ❒ Pain in upper arm R L
- ❒ Pain in forearm R L
- ❒ Pain in hand R L
- ❒ Pain in wrist R L
- ❒ Finger pain R L
- ❒ Pinched nerve in arm R L
- ❒ Pinched nerve in finger R L
- ❒ Sensation of pins and needles in arms R L
- ❒ Fingers go to sleep R L
- ❒ Hands feel cold R L
- ❒ Swollen joints in fingers R L

MID-BACK
- ❒ Mid-back pain
- ❒ Mid-back pain is worse when I :
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ turn left ❒ turn right
- ❒ Pain between shoulder blades
- ❒ Sharp stabbing pain
- ❒ Muscle spasms

CHEST:
- ❒ Chest pain
- ❒ Shortness of breath
- ❒ Pain around ribs
- ❒ Asthma
- ❒ Cough

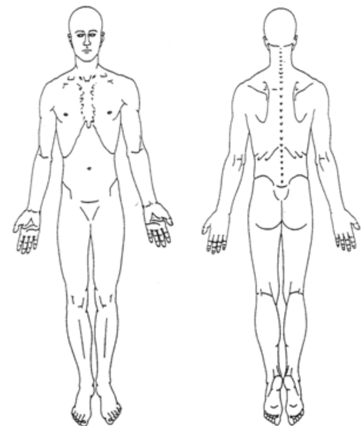
ABDOMEN:
- ❒ Nervous stomach
- ❒ Nausea
- ❒ Gas
- ❒ Constipation
- ❒ Diarrhea

LOW BACK
- ❒ Low back pain
- ❒ Low back pain is worse when I:
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ twist left ❒ twist right
  - ❒ walk ❒ sit
  - ❒ stand ❒ lift
  - ❒ cough ❒ sneeze
  - ❒ stoop ❒ work
  - ❒ bowel movements
- ❒ Pinched nerve in low back
- ❒ Low back feels out of place
- ❒ Tailbone pain
- ❒ Tailbone pain is worse when I:
  - ❒ bend left ❒ bend right
  - ❒ twist left ❒ twist right
  - ❒ lift ❒ cough
  - ❒ sneeze ❒ stoop
  - ❒ work ❒ walk
  - ❒ bowel movements
- ❒ Muscle spasms low back
- ❒ Arthritis in low back

HIPS, LEGS, & FEET:
- ❒ Pain in buttocks R L
- ❒ Buttock pain is worse when I:
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ twist left ❒ twist right
  - ❒ walk ❒ sit
  - ❒ stand ❒ lift

HIPS, LEGS & FEET CONT.
  - ❒ cough ❒ sneeze
  - ❒ stoop ❒ work
  - ❒ bowel movements
- ❒ Pain in hip joints R L
- ❒ Hip joint pain is worse when I:
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ twist left ❒ twist right
  - ❒ walk ❒ sit
  - ❒ stand ❒ lift
  - ❒ cough ❒ sneeze
  - ❒ stoop ❒ work
  - ❒ bowel movements
- ❒ Pain down legs R L
- ❒ Leg pain is worse when I:
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ twist left ❒ twist right
  - ❒ walk ❒ sit
  - ❒ stand ❒ lift
  - ❒ cough ❒ sneeze
  - ❒ stoop ❒ work
  - ❒ bowel movements
- ❒ Leg cramps R L
- ❒ Sensation of pins and needles in legs R L
- ❒ Numbness in feet R L
- ❒ Numbness in legs R L
- ❒ Numbness in toes R L
- ❒ Feet feel cold R L
- ❒ Cramps in feet R L
- ❒ Swollen ankles R L
- ❒ Swollen feet R L
- ❒ Painful joints in toes R L

PLEASE MARK AN "X" WHERE YOU FEEL PAIN, TINGLING, OR NUMBNESS.



____
Patient Signature

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health Insurance Company (or Companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For you security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

______________________________________ ______________
Name of Patient Date

JM04

____
Signature of Patient

INFORMED CONSENT TO
CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries in the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks of complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, is/are in my best interest.

I have an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ❒ or have had read to me ❒ the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

Name and Address of Treating Doctor and or Clinic

Todd B. Andrews D.C.
1501 N. Placentia Ave.
Placentia, CA 92870
(714) 572-3834

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE

____
Printed Name of Patient

____ ________________
Signature of Patient Date

____ ________________
Signature of Patient's Representative (if minor or incapacitated) Date

____ ________________
Witness to Patient's Signature Date

____ ________________
Translated By Date