DR. CARMONA CHIROPRACTIC

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Phone: (949) 229.7655

TODAY'S DATE: _____

PERSONAL DATA

Name _____ Age _____ Date of Birth _____

Both Parent's names (if you are under 18) _____

Home Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Cell Phone (____) _____

E-mail address_____@ _____

Occupation _____ Employer _____

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ L/W Spouse/Partner _____

HOW DID YOU FIND DR. CARMONA, D.C.: _____

EMERGENCY CONTACT PERSON: NAME: _____

PHONE NUMBER: (___) _____

WHAT IS YOUR REASON FOR SEEKING CHIROPRACTIC CARE?

_____

_____

_____

ARE THESE CONCERNS AFFECTING YOUR QUALITY OF LIFE? (PLEASE MARK ALL THAT APPLY)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

Explain:_____

_____

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑_____ years

Date of last visit: _____ Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason:

_____

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list.
Please list the major traumas that you remember from your childhood up to the present.
Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

_____

Have you ever hurt, broken, fractured, sprained, injured, or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs, or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: _____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N

If yes, please list: _____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter): _____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

FOR WOMAN (SKIP TO QUALITY-OF-LIFE QUESTION IF NOT APPLICABLE)

Are you pregnant? Y N Date of last menstrual period: _____

If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.

Signature: _____ Date: _____

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife _____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other _____

QUALITY OF LIFE (presently)

How do you grade your physical health?	❑ Good	❑ Fair	❑ Poor
How do you grade your emotional/mental health?	❑ Good	❑ Fair	❑ Poor
How do you rate your overall “quality of life”?	❑ Good	❑ Fair	❑ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

WHAT ARE YOUR EXPECTATIONS FROM CHIROPRACTIC CARE? (Check all that apply)

- ❒ Relief of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Improved overall health
- ❒ OTHER_____

CANCELLATION POLICY (INITIAL REQUIRED)

Cancellation Policy: In the event that the client needs to cancel their appointment, they must provide a minimum of 24 hour notice. Failure to do so will result in a $50 no show fee, applicable for clients who do not show up for their appointment or fail to notify us within the 24-hour period.

INITIAL:_____

INSURANCE INFORMATION:

Subscriber: _____Insurance Co:_____
Subscriber Date of Birth: _____Member ID #:_____
Group #:_____

PLEASE READ AND SIGN

CONSENT TO TREAT:

1. I, the undersigned, hereby consent to receiving communication from Dr. Heather Carmona, D.C. through various channels, including email, postal mail, text, and telephone messaging, for the purpose of managing my care. I understand that this consent can be withdrawn at any time by providing written notification to the office. Furthermore, I acknowledge that I have been duly informed of the nature, risks, and benefits of the proposed treatment. I have been informed of the Carmona Chiropractic *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* information.

   INITIAL:_____

2. The client acknowledges and confirms that all the information provided on the case history form is true and accurate to the best of their knowledge. By signing this agreement, the client grants Dr. Heather Carmona, D.C. full permission to provide necessary care and treatment, which may include a health history consultation and chiropractic examination during the initial visit. The client understands that the purpose of this visit is to assess their health condition and determine the appropriate chiropractic care needed.

   INITIAL:_____

Name: (Printed) _____ Date: _____

Signature: _____

Signature of Parent (for minor): _____ Date: _____

Thank you for choosing Dr. Heather Carmona, DC
I look forward to helping you.