Weitz Sports Chiropractic and Nutrition

Ben Weitz D.C. C.C.S.P.

1448 15th Street, Suite 201 Santa Monica, CA 90404

Patient Information:

Patient Name: _____ Birthdate: _____ Sex: M / F

Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____

Email: _____

Referred by: _____ Other Doctors Seen for this Condition: _____

Primary Language: _____ Occupation: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Emergency Contact Information:

Name: _____ Phone Number: _____

Credit Card on File:

If you would like to keep your credit card on file for convenience, please fill out the information below:

Card Type: [ ] Visa [ ] Mastercard [ ] American Express [ ] Discover [ ] Other: _____

Cardholder's Name: _____

Credit Card Number: _____ EXP. Date: _____

CVV: _____ Billing Zip Code: _____

I, _____ , authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be save to file for future transactions on my account.

Customer's Signature: _____ Date: _____

I certify to the best of my knowledge; the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health cate benefit through this provider. I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health coverage in the future.

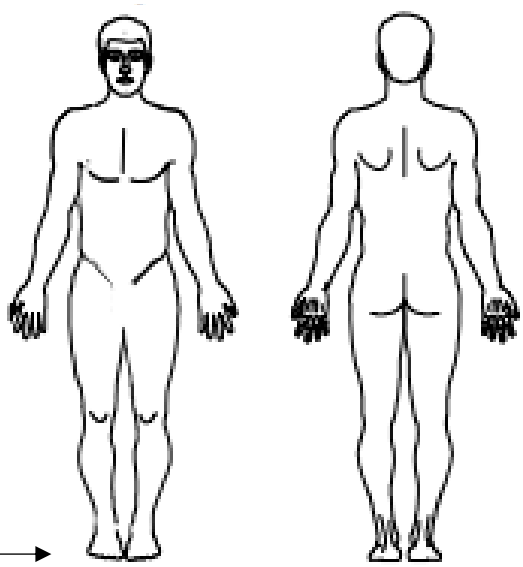
Patient's Signature: _____ Date: _____

Patient Name: _____

Patient History:

Present Weight: _____ lbs. Height:___Ft. ___in.

Mark an X on the picture where you have pain or other symptoms:



Describe your current problem and how it began:

[ ] Headache [ ] Neck Pain [ ] Mid-back Pain [ ] Low back pain

[ ] Other:

Is this? [ ] Work Related [ ] Auto Related [ ] N/a

Date Problem Began:

How Problem Began:

Current Complaint (how are you feeling today?:

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

[ ] Intermittent 0-25% [ ] 26-50% [ ] 51-75% [ ] Constant 76-100%

In the past week, how much has your pain interfered with your daily activities (work, social activities, household work)

0 1 2 3 4 5 6 7 8 9 10

No Interference Unable to carry on any activities

Have you had spinal X-RAYS, MRI, CT scans for your area(s) of complaint? [ ] Yes [ ] No

If yes: Date Taken: _____ What areas were taken? _____

When did your problem start (approximately)? _____

How often are your symptoms present? [ ] Constantly [ ] Frequently [ ] Occasionally [ ] Intermittently

Describe your current pain/symptoms: [ ] Sharp/Stabbing [ ] Throbbing [ ] Aches [ ] Dull

[ ] Soreness [ ] Weakness [ ] Numbness [ ] Shooting

[ ] Gripping [ ] Burning [ ] Tingling

[ ] Other: _____

Since it began, is your problem: [ ] Improving [ ] Getting Worse [ ] No Change

What makes the problem worse?: [ ] Nothing [ ] Lying Down [ ] Walking [ ] Standing

[ ] Sitting [ ] Movement [ ] Exercise [ ] Inactivity/Rest

[ ] Other: _____

Patient Name: _____

What makes the problem better? [ ] Nothing [ ] Lying Down [ ] Walking [ ] Standing

[ ] Sitting [ ] Movement [ ] Exercise [ ] Inactivity/Rest

[ ] Other: _____

Can you preform your daily home activities? [ ] Yes [ ] Yes, but only with help [ ] Not at all

Do you exercise? [ ] Yes, almost daily [ ] Yes, occasionally [ ] Not at all

Describe your job requirements: [ ] Mainly sitting [ ] Light labor [ ] Heavy labor

Can you preform your daily work activities? [ ] Yes, all activities [ ] Only some [ ] Not at all

Describe your stress level: [ ] None to mild [ ] Moderate [ ] High

What treatment(s) have you had for this condition? (Surgery, medications, injections, therapy, chiropractic, etc.)

_____

Do you smoke? [ ] Yes [ ] No [ ] Used to smoke, but not currently

Coffee/Tea/Caffeinated soft drinks: Cups/cans per day:

Please list all medications you currently take: _____

_____

Please list all supplements you currently take: _____

_____

Family History:

Please check all of the following that apply to you:

- [ ] Recent Fever
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Stroke (date) _____
- [ ] Corticosteroid use (cortisone, prednisone, etc.)
- [ ] Taking Birth Control Pills
- [ ] Dizziness/Fainting
- [ ] Numbness in Groin/Buttocks
- [ ] Cancer/Tumor (explain): _____
- [ ] Osteoporosis/ Osteomalacia
- [ ] Asthma
- [ ] Prostate Problems
- [ ] Menstrual Problems
- [ ] Urinary Problems
- [ ] Currently Pregnant # of weeks: _____
- [ ] Abnormal Weight [ ] Gain [ ] Loss
- [ ] Marked Morning Pain/stiffness
- [ ] Pain Unrelieved by Position or Rest
- [ ] Pain at Night
- [ ] Visual Disturbances
- [ ] Epilepsy/Seizures
- [ ] Arthritis

Other health problems: _____

_____

Surgeries: _____

_____

Family History: [ ] Cancer [ ] Diabetes [ ] High Blood Pressure [ ] Heart Problems/Stroke

[ ] Rheumatoid Arthritis [ ] Other: _____

Financial Responsibility and Assignment of Benefits:

Do you have insurance? [ ] Yes [ ] No If no: please read information and sign below.

Insurance Carrier: _____ Subscriber ID:_____

Health Plan: _____ Group Number: _____

Social Security Number: _____

Are you the primary subscriber on this plan? [ ] Yes [ ]No

If no: Primary Subscriber's Name: _____ Date of Birth: _____

To provide timely and accurate payment to Weitz Sports Chiropractic and Nutrition for any services rendered by the patient listed above by Dr. Ben Weitz and staff:

• I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.

• I assign my right to receive payment of authorized benefits to Weitz Sports Chiropractic and Nutrition.

• I request that payment of authorized benefits be made on my behalf to Weitz Sports Chiropractic and Nutrition* for any services furnished the patient listed above by Dr. Ben Weitz and staff.

• If my Health Insurance Plan will not direct payment to Weitz Sports Chiropractic and Nutrition, I agree to forward to Weitz Sports Chiropractic and Nutrition all health insurance payments which I receive for the services rendered by Dr. Ben Weitz and staff.

• I authorize Weitz Sports Chiropractic and Nutrition or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:

• That I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____ _____

Patient Signature Patient Name (printed) Date

Informed Consent Document

<u>To the Patient</u>: Please read the entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign, if there is anything that is unclear.

The Nature of the Chiropractic Adjustment: The primary treatment used by doctors of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	palpation	vital signs
range of motion testing	orthopedic testing	basic neurological testing
muscle strength testing	postural analysis	EMS
ultrasound	hot/cold therapy	radiographic studies

The material risks inherent in Chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options: Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options, and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Ben Weitz* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment, and I have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name_____ **Signature**_____ **Date:** _____