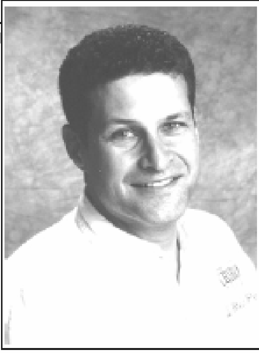
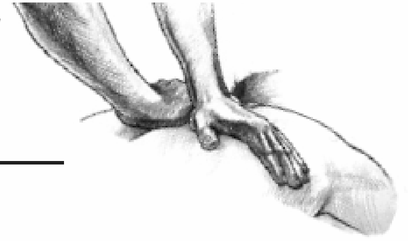


DR. STEVEN B. PERRY
CHIROPRACTOR

18740 Ventura Boulevard, Suite 106
Tarzana, California 91356
(818) 881-BACK (2225)



THE **New Patient**

OUTLINE OF PROCEDURES FOR CARE

1. All new patients are requested to fill in **paperwork**.

2. A one-on-one **consultation** with Dr. Perry will be done to discuss your health problems and to determine what may be the cause.

3. A comprehensive **examination and evaluation** is given, including those tests necessary to determine the precise cause of your problems.

4. You will be given a **report of findings** at which time the cause of your problems will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained.

ACCOUNT NO:

PERSONAL HISTORY

Type of Case: ☐ Private pay ☐ Insurance ***IF THIS IS AN AUTO OR WORK ACCIDENT, PLEASE ASK FOR ACCIDENT FORM.***

First Name ________________________ **Middle Initial**____ **Last Name** ________________________ **Date** __________________

Street Address____

City____ **State**______________________ **Zip**________________

E-Mail____ **Home Phone**______________________________________

Date of Birth________________________ **Sex:** ☐ Male ☐ Female **Social Security No**__________________________________

Age______________ **Driver's License Number**__________________________ **Marital Status:** ☐ M ☐ S ☐ D ☐ W ☐ SEP

Occupation____ **Employer**______________________________________

Employer Street Address____

City____ **State**______________________ **Zip**________________

Work E-Mail____ **Work Phone**______________________________________

Who referred you?____

INSURANCE INFORMATION

Insurance Company Name____

Street Address____

City____ **State**______________________ **Zip**________________

Phone____ **Adjuster**______________________________________

Policy No_________________________ **Claim No**________________________ **Group or Plan No**___________________________

INSURED INFORMATION

First Name _____________________________________ **Middle Initial**____ **Last Name** ____________________________________

Insured's ID No ____ **Date of Birth**_____________________ **Sex:** ☐ Male ☐ Female

Insured's Relationship ☐ Spouse ☐ Parent ☐ Child ☐ Other____

CURRENT HISTORY

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic

Did your injury occur during: ☐ Sports/ Play ☐ Accident ☐ Routine/ Household activity ☐ Other_________________________

When did your condition/ accident occur? ________________ **Where did your injury occur?** ______________________________

Please explain what happened: ____

____

____

____

____

____

____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

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PERSONAL HISTORY

First Name ________________________**Middle Initial**____ **Last Name** ___________________________

CURRENT HEALTH CONDITION(S)

Using the adjacent body charts, please *circle* all affected areas.

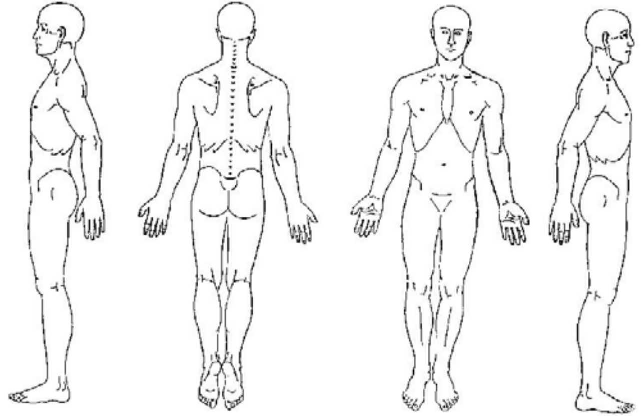
What is / are your unwanted health condition(s)?

1. ____
2. ____
3. ____
4. ____

Have you been treated by another physician for this / these condition(s)?

☐ Yes ☐ No If so, please list other Doctors:

1. ____
2. ____
3. ____



LEFT **BACK** **FRONT** **RIGHT**

My condition is aggravated by:

☐ Standing too long	☐ Sneezing	☐ Laying on my back	☐ Bowel movement	☐ Stooping
☐ Sitting too long	☐ Coughing	☐ Laying on my stomach	☐ Pushing	☐ Vacuuming
☐ Driving	☐ Pulling	☐ Bending	☐ Sex	☐ Lifting over __________lbs.

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine **If so, how:** ____

____

Are you taking any of the following medications? ☐ Nerve Pills ☐ Pain Killers (including Aspirin) ☐ Muscle Relaxants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) ____

Please list any surgeries with dates and/ or any other serious medical condition(s) not listed above: ______________________________

____

List any past serious accidents with dates: ____

Please list anything that you may be allergic to: ____

Family Health History: ____

Do you have or have you had any of the following diseases, medical conditions or procedures?

MUSCULO-SKELETAL

- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Upper Extremity Arm Pain
- ☐ Lower Extremity Leg Pain
- ☐ General Stiffness
- ☐ Jaw Pain
- ☐ Artificial Joints/ Implant
- ☐ Other__________________

FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain / Infection
- ☐ Breast Pain/Lump

Last Period________________

Are you pregnant?

☐yes ☐no ☐not sure

How many weeks? ________

MALE

- ☐ Prostate / Sexual Dysfunction

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Tingling Extremities
- ☐ Paralysis
- ☐ Depression
- ☐ Confusion
- ☐ Stress
- ☐ Fainting / Seizures / Convulsions
- ☐ Dizziness
- ☐ Shingles
- ☐ Psychiatric Problems

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

GASTRO-INTESTINAL

- ☐ Colitis
- ☐ Ulcers
- ☐ Black or Bloody Stool
- ☐ Heartburn
- ☐ Vomiting / Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver / Gall Bladder
- ☐ Hepatitis
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas / Bloating
- ☐ Kidney Problems

CARDIO-VASCULAR-RESPIRATORY

- ☐ Irregular Heartbeat
- ☐ Heart Attack / Stroke
- ☐ Artificial Valves
- ☐ Heart Murmur
- ☐ Heart Surgery / Pacemaker
- ☐ Mistral Valve Prolapse
- ☐ Shortness / Difficulty Breathing
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Chest Pain
- ☐ Congenital Heart Defect
- ☐ Lung Problems
- ☐ Emphysema/ Asthma
- ☐ High/ Low Blood Pressure
- ☐ Stroke
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Rheumatic Fever

GENERAL

- ☐ Fatigue
- ☐ Venereal Disease
- ☐ Alcohol / Drug Abuse
- ☐ Allergies
- ☐ Fever
- ☐ Anemia
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Arthritis
- ☐ Headaches
- ☐ Thyroid
- ☐ Eczema
- ☐ Polio

EYES & ENT

- ☐ Vision Problem
- ☐ Dental Problem
- ☐ Ear Problem
- ☐ Hearing Problem
- ☐ Sore Throat
- ☐ Sinus / Stuffy Nose
- ☐ Glaucoma

PERSONAL HISTORY

First Name ________________________Middle Initial____ Last Name ________________________

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, *unless other arrangements have been made with the business manager*. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- 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 to me are charged directly to me and that I am personally responsible for payment. I suspend or terminate any fees for professional services rendered to me will be immediately due and payable.
- I authorize the doctor and staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature ____ Date _____________

Consent to Treat a Minor ____ Date _____________

☐ Parent or Guardian

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