DR. STEVEN B. PERRY
CHIROPRACTOR

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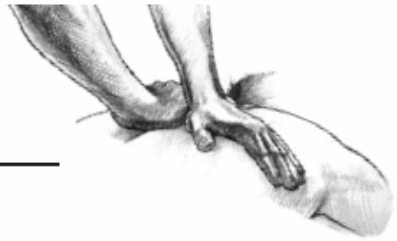
(818) 881-BACK (2225)



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 INJURY HISTORY

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**_____

AUTO INSURANCE INFORMATION

Insurance Company Name _____

Street Address_____

City_____ **State**_____ **Zip**_____

Phone_____ **Agent's Name**_____

Policy Holder's Name_____ **Policy No**_____ **Claim No**_____

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

HEALTH 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_____

ATTORNEY

Name _____

Street Address_____

City_____ **State**_____ **Zip**_____

Phone _____ **Fax**_____

PERSONAL INJURY HISTORY

First Name _____**Middle Initial**____ **Last Name** _____ **Date** _____

NATURE OF ACCIDENT

Did your injury occur during? ☐ Auto Accident ☐ Slip and Fall ☐ Pedestrian ☐ Other_____

When did your accident occur? _____ **Time of accident**:_____ ☐ a.m. ☐ p.m. Approximate

Were you: ☐ Driving ☐ Passenger ☐ Front Seat ☐ Back Right ☐ Back Left ☐ Walking ☐ Other_____

Name of city where accident occurred _____

What direction were you headed? ☐ North ☐ South ☐ East ☐ West

Name of Street__

Cross Street__

What direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West

Name of Street_

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side **Were there any witnesses?** ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No **If yes, did they inflate?** ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: _____

During impact, were you facing: ☐ Right ☐ Left ☐ Forward **Were you:** ☐ Aware of the impact ☐ Surprised by the impact

Describe the damage to your car_____

Describe the damage to the other car_____

Were you able to drive your car after the accident? ☐ Yes ☐ No **Did the police take a report?** ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No

If yes, how did you get there?_____

At the hospital / ER what did they do for you?_____

Were you knocked unconscious? ☐ Yes ☐ No

In you own words, please explain what happened: _____

_____

_____

_____

_____

_____

_____

Describe how you felt and what areas hurt

During the accident: _____

Immediately after the accident: _____

Later that day:_____

The next day:_____

PERSONAL INJURY HISTORY

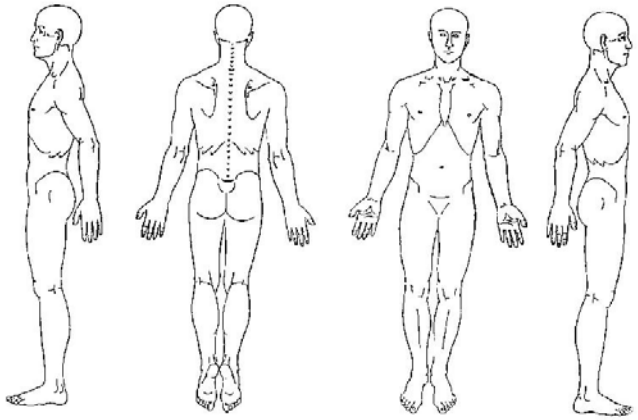
First Name _____**Middle Initial**____ **Last Name** _____ **Date** _____

CURRENT HEALTH CONDITION(S)

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

What area(s) is / are injured?

1. _____
2. _____
3. _____
4. _____



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

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

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

1. _____
2. _____
3. _____

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:** _____

_____

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

Have you missed work because of the accident? ☐ Yes ☐ No **If yes, Date of Disability** From _____ to _____

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): _____

_____

List any past accidents with dates: _____

Do you have 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 INJURY HISTORY

First Name _____Middle Initial____ Last Name _____ Date _____

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