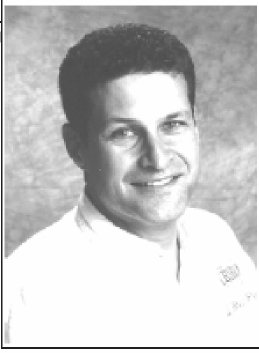
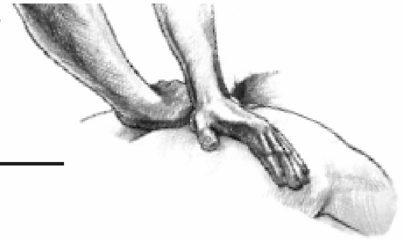


DR. STEVEN B. PERRY
CHIROPRACTOR

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:

OCCUPATIONAL INJURY

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

WORKER'S COMPENSATION INSURANCE INFORMATION

Insurance Company Name____

Street Address____

City____ **State**______________________ **Zip**___________________

Phone____ **Fax Number**____

Adjuster___________________________ **Claim No**_________________________ **WCAB No**_______________________________

Has your insurance company / employer sent you any information regarding MPN's? ☐ Yes ☐ No **If yes when?** _______________

JOB INFORMATION

Employer____

Employer Street Address____

City____ **State**______________________ **Zip**_____________________

Work E-Mail____ **Work Phone**_______________________________________

Nature of business (e.g. food manufacturing, building construction, retailer of women's clothes) __________________________________

Occupation (Specific Job Title) ____

In a typical 8 hour workday, I : (Circle number of hours for each activity)

Sit:	1	2	3	4	5	6	7	8	Hours
Stand:	1	2	3	4	5	6	7	8	Hours
Walk:	1	2	3	4	5	6	7	8	Hours

On the job, I perform the following activities:

	Not at all	Occasional (1-33%)	Frequent (34-66%)	Constant (67-100%)
Bend / Stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Push / Pull	☐	☐	☐	☐
On the job, I lift:				
Up to 10 pounds	☐	☐	☐	☐
11 to 24 pounds	☐	☐	☐	☐
25 to 34 pounds	☐	☐	☐	☐
35 to 50 pounds	☐	☐	☐	☐
51 to 74 pounds	☐	☐	☐	☐
75 to 100+ pounds	☐	☐	☐	☐

OCCUPATIONAL INJURY

Do you have to bend over while doing any lifting? ☐ Yes ☐ No
Do you use your hands to do repetitive actions?
Simple Grasping ☐ Yes ☐ No **Firm Grasping** ☐ Yes ☐ No **Fine Manipulation** ☐ Yes ☐ No
Do you work at unprotected heights? ☐ Yes ☐ No
Do you work around moving machinery? ☐ Yes ☐ No
Are you exposed to marked changes in temperature and humidity? ☐ Yes ☐ No
Are you required to drive automotive equipment? ☐ Yes ☐ No Describe____
Are you exposed to dust, fumes and or gases? ☐ Yes ☐ No
List any additional comments:____

____

PERSONAL INFORMATION

First Name ________________________**Middle Initial**____ **Last Name** ________________________ **Date** ________________
Street Address____
City____ **State**_______________________ **Zip**________________
E-Mail____ **Home Phone**____
Date of Birth______________ **Age**_________ **Sex:** ☐ Male ☐ Female **Social Security No**________________________________
Driver's License Number____ **Marital Status:** ☐ M ☐ S ☐ D ☐ W ☐ SEP
Who referred you?____

DESCRIBE HOW THE ACCIDENT OCCURED

(Give specific object, machinery or chemical):
When did your condition/ accident occur? _____________________**Time of accident:** _____________________ ☐ a.m. ☐ p.m.
Where did your injury occur? ____
Street Address____
City____ **State**_______________________ **Zip**_________________
Please explain what happened: ____

____

____

____

____

____

____

____

Was anyone else present during your accident? ☐ Yes ☐ No **Did you report your accident to your employer?** ☐ Yes ☐ No
What recommendations did your employer make just after your accident? ____

____

OCCUPATIONAL INJURY

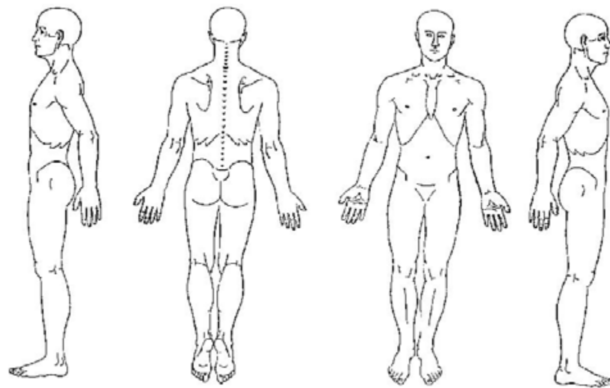
First Name _______________________**Middle Initial**____ **Last Name** _______________________ **Date** _________________

COMPLAINT(S)

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

What area(s) is / are injured?

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. ____

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) ____

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
☐ Mitral 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

OCCUPATIONAL INJURY

First Name ______________________**Middle Initial**____ **Last Name** ______________________ **Date**_____________

HISTORY

List all doctors who have either examined or treated you for this injury:

1. ______________________________________Specialty____________________ City________________________
2. ______________________________________Specialty____________________ City________________________
3. ______________________________________Specialty____________________ City________________________

List prior industrial / work injuries:

1. Employer________________________________Date_______________Part Injured__________________________
2. Employer________________________________Date_______________Part Injured__________________________
3. Employer________________________________Date_______________Part Injured__________________________

List prior non-industrial / work injuries:

1. ____Date______________ Part Injured__________________________
2. ____Date______________ Part Injured__________________________
3. ____Date______________ Part Injured__________________________

Please list any surgeries with dates and / or any other serious medical conditions not listed above:

____

____

Please list anything that you may be allergic to: ____

Family Health History: ____

WORK STATUS

Are you working now? ☐ Yes ☐ No **If no, Date of Disability:** From ____________________ to ___________________

Are you able to perform usual work? ☐ Yes ☐ No **If no, what job are you doing and what are you doing different:**

(Modified Work / Specify Restrictions) ____

____

ATTORNEY

Name ____

Street Address____

City____ **State**______________________ **Zip**_______________

Phone ____ **Fax**____

OCCUPATIONAL INJURY

First Name ________________________Middle Initial____ Last Name ________________________ Date______________

Most patients that come to our office have on 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.
- 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 ______________

WC 11-09-05