Redondo Family Chiropractic Center

Today's Date______

Name ____ Home Phone ___________________________

Address ____________________________________ Cell Phone ______________________________

City, State, Zip ________________________________ Email Address __________________________

Birth date ________________ Age _______________ SS# _____________________________________

Occupation _____________________________ Employer ____________________________________

Marital Status: S M D W Spouse Name ________________________ # of children ___________

1. Most of our patients are referred to our office by a caring family member or friend. How did you hear about Redondo Family Chiropractic Center?
   Friend ________________________ Yellow Pages Mailing
   Referred by Dr. ________________ Sign Lecture
   Newspaper ____________________ Health Fair Other ______________________

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? ________________________ Never

3. When was the last time you had a complete spinal examination including x-rays?______________

4. Have you ever been told you have a spinal curvature, spinal arthritis, or inherited a spinal problem?
   Yes No

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? Yes No

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or back? Yes No

7. Stress and Physical trauma causes and accelerates spinal damage.
Have you ever been in a car accident (even minor)? Yes No If yes when _____________________
Have you ever had a fall or sports injury? Yes No If yes when ______________________________
Do you, or have you ever, worked at a desk or a computer? Yes No If yes when _________
Do you, or have you ever, had to do repetitive lifting? Yes No If yes when _________
How would you rate the amount of stress in your life? low moderate high

8. SUBLUXATION in the neck can cause the following problems. Please check off any that you have experienced in the past 12 months.

Tension across top of shoulders	Thyroid/Throat problems	Poor Vision/Eye problems
Pain between shoulder blades	Numbing/Tingling in arms/hands	Difficulty sleeping
Neck Pain	Allergies/Asthma	Tinnitus/Hearing problems
Headaches/Migraines	Dizziness	Depression
TMJ	Arthritis/Joint Pain	ADD/ADHD
Carpal Tunnel Syndrome	Fibromyalgia	Frequent Colds

SUBLUXATION in the mid-back can cause the following problems. Please check off any that you have

experienced in the past 12 months.

High/Low Blood Pressure	Diabetes/Blood Sugar problems	Acid Reflux/Stomach Problems
Breathing Problems	Poor Digestion	Fatigue/Low Energy
Mid-back/Shoulder Pain	Anxiety/Overwhelmed feeling	Stress-related problems
Digestive Problems	Eczema/Psoriasis/Dry Skin	Autoimmune/Rheumatism

SUBLUXATION in the lower back and hips can cause the following problems. Please check off any that you have experienced in the past 12 months.

Low Back Pain	Infertility/Inability to get pregnant	Sciatica/Leg pain
Gas/Bloating	Menstrual problems/PMS syndrome	Knee/Ankle/Hip problems
Irritable Bowel Syndrome	Numbing/Tingling in legs/feet	Sexual Dysfunction
Constipation/Diarrhea	Prostate problems	Muscle pain in the hips/buttocks

9. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. Please list all the drugs you are taking, what you are taking each for, and what side effects you've noticed.
DRUG WHAT FOR? SIDE EFFECTS

____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

10. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury? Yes No If yes when ____

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11. Spinal health is especially important during pregnancy. Is there any chance you are pregnant?
Yes No If yes when ____

12. Children can experience spinal stress and trauma, which if not found early can lead to problems now or later in life. Have your children ever had a spinal checkup by a chiropractor? Yes No

13. If the doctor feels that chiropractic will help you, are you willing to follow his recommendations?
Yes No If no, what might stop you from following them?______________________

14. How would you rate your health in the following categories (1=bad, 10=perfect)
ENERGY LEVELS (without caffeine or other stimulants) 1 2 3 4 5 6 7 8 9 10
MENTAL CLARITY (without caffeine or other stimulants) 1 2 3 4 5 6 7 8 9 10
SLEEP QUALITY (how refreshed do you feel in the morning) 1 2 3 4 5 6 7 8 9 10
FLEXIBILITY (ease of movement, bending, turning, etc.) 1 2 3 4 5 6 7 8 9 10
DIGESTIVE HEALTH (normal is 2-4 bowel movements/day) 1 2 3 4 5 6 7 8 9 10
OVERALL HEALTH 1 2 3 4 5 6 7 8 9 10

15. If you keep doing the same things you are doing, and fail to make proper changes, what do you see happening to your health in the next FIVE YEARS?
Spontaneous improvement   stay the same   gradually get worse and worse

16. What is your goal and objective for your care in our office?
Pain relief only   Full correction of the problem   Optimal Health and Wellness

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Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.
Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

Assignment and release (FOR PATIENTS WITH HEALTH INSURANCE)
I certify that I (or my dependent) have health insurance benefits with ____________________, and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO REDONDO FAMILY CHIROPRACTIC CENTER. THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges from Redondo Family Chiropractic Center, whether or not covered or paid by my insurance company. I hereby authorize all doctors and employees of Redondo Family Chiropractic Center, to release any information necessary, including diagnosis and records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Signature of patient or guardian ____________________________________Date ___________

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

Date ________________________________ Time ______________________ AM / PM

I have been informed by Dr. James Redondo that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr James Redondo to perform such radiographic examination necessary to diagnose, and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed: ______________________________________

To the best of my knowledge I am NOT pregnant and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed: ______________________________________