



Sandy Sachs, D.C. ■ Rex Stevens, D.C. ■ Molly Stevens, D.C.
1428 Phillips Lane ■ Suite 300 ■ TEL 805.543.8688 ■ FAX 805.543.8732

Please answer every question below so that we can provide you with the best possible service.

SECTION 1

Today's date: ___/___/___ File #: _____
Name: _____
What do you prefer to be called?: _____
Male ___ Female ___ Birth Date: ___/___/___ Age: ___ SSN#: ___-___-___
Mailing address: _____
City State Zip
How would you like to receive your appointment confirmation in the future? [] Email [] Text [] Phone call
Email address: _____
Home phone #: _____ Cell Phone #: _____
Whom may we thank for referring you?: _____
Who is your employer?: _____
Employer's address: _____
City State Zip
Occupation: _____ Work #: _____
Marital Status: [] Single [] Married [] Divorced [] Separated [] Widowed [] Domestic Partner
Children: [] Yes [] No Number of children _____

SECTION 2

(Please read carefully and initial)
SLO Wellness Center (SWC) is a partnership between Sachs Chiropractic Inc. and Stevens Chiropractic Inc.
SWC invites you to discuss with us any questions regarding your care and our services. The best health care is based on a friendly, mutual understanding between provider and patient.
SWC requests payment in full for all services at the time of visit, unless other arrangements have been made.
___ I understand that SWC can bill my insurance as a courtesy and I am ultimately responsible for payment of services provided.
___ I hereby authorize SWC and whomever they designate to administer treatment as they so deem necessary. I also authorize the provider(s) and / or managed care organization to release my information to provide other health care providers with information related to my care as well as to process insurance claims.
___ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by [] Rex Stevens, D.C. [] Molly Stevens, D.C. [] Sandy Sachs, D.C.
___ I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I authorize the treating doctor to provide the necessary treatment that is within the scope and common practice of the chiropractic license in the State of California.
___ I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment from my present condition(s) and for any future condition(s) for which I seek treatment in this office.

Signature: _____ Date: _____

We look forward to being YOUR resource for chiropractic care on the central coast
- Drs. Rex and Molly Stevens, Dr. Sandy Sachs

S E C T I O N 3

Name: _____

Please explain the primary reason for visiting our office:

- 1. _____
- 2. _____
- 3. _____

When did your current condition begin? _____ / _____ / _____

Have you ever had this condition before? Yes No If so, please describe:

Was this the result of an accident? yes no

If yes, was it from auto work-related other _____

Would you describe the problem as getting better getting worse constant comes and goes?

Is the problem interfering with your work, sleep, daily routine? If so, please describe: _____

Have you sought any other treatment before this? Yes No If so, please describe: _____

Have you ever been to a chiropractor before? Yes No If so, whom? Name: _____

Where? _____ What did you enjoy most about their care? _____

What other forms of health care do you use? Acupuncture

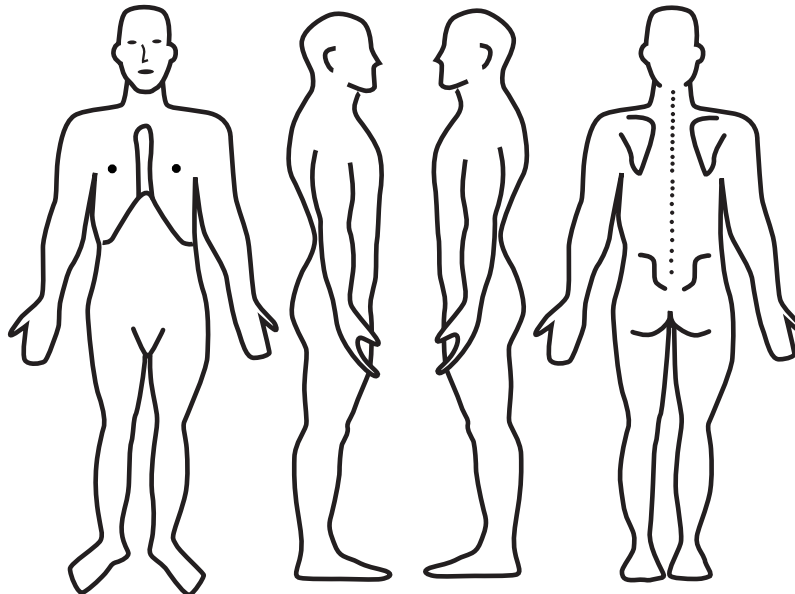
Massage _____

MD _____ name

Other _____

S E C T I O N 4

Please show me where you are experiencing pain and/or discomfort:



Front

Right

Left

Back

S E C T I O N 5

Name: _____

Please list any supplements you are taking, including vitamins, herbs, etc.?

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

Please list any medications you are taking, including over the counter meds?

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

Have you had any of the following condition(s)?

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart attack/stroke | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Congenital Heart defect | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shingles | <input type="checkbox"/> Emphysema/ Glaucoma |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Arthritis (type)_____ | <input type="checkbox"/> Cancer (type)_____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers/Colitis |
| <input type="checkbox"/> Diabetes/Tuberculosis | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Eye Disorders |

Please list any other serious medical conditions you have or ever had:

Medical Conditions

Surgeries

Serious Accident/Trauma

- | | | |
|----------|----------|----------|
| 1. _____ | 1. _____ | 1. _____ |
| 2. _____ | 2. _____ | 2. _____ |
| 3. _____ | 3. _____ | 3. _____ |

Please list anything you may be allergic to:

S E C T I O N 6

Health habits:

What do you do for physical activity? _____

What are your hobbies? _____

I eat **1 2 3 4 5 >5 (circle one)** meals per day

My diet consists of **(circle all that apply)**: fruits, vegetables, chicken, fish, beef, fast foods, sodas, caffeine

I drink approximately _____ cups of water/day

How much un-interrupted sleep do you get per night? _____

I sleep on my **(circle all that apply)** back side (R/L) stomach

My pillow is **(circle one)** too hard too soft just right

How old is your mattress? _____ Is it comfortable? _____

Would you be interested in additional information regarding:

- 1. Therapeutic Pillows yes no
- 2. Vitamin Supplementation yes no
- 3. Orthotics/foot supports yes no

Do you smoke? No Yes/ How much? _____ For how long?

Name: _____

Please check if you experience or have experienced:

Past Present

- Headaches
- Migraines
- Insomnia
- Dizziness
- Loss of Smell
- Ringing in Ears
- Loss of Balance

- Sinus Trouble
- Recurrent Sore Throat
- Chronic Cough
- Skin Conditions
- Allergies
- Asthma
- Eczema/Rash
- Scalp Disorders

- Poor Memory
- Anxiety
- Rapid Heart Rate
- Depression

Past Present

- Vomiting
- Constipation
- Diarrhea
- Urinary Disorder
- Bed-wetting
- Digestive Disorder

- Pain in Head
- Pain in Jaw/TMJ
- Neck Soreness
- Shoulder Pain
- Shoulder Stiffness
- Shoulder Tension
- Arm Pain
- Tennis Elbow
- Loss of Arm Power
- Pins & Needles in Hands
- Loss of Grip

Past Present

- Mid-back Pain
- Mid-back Tension
- Pain in Ribs
- Low Back Pain

- Low Back Weakness
- Low Back Stiffness
- Hip Pain/Stiffness
- Buttock Pain
- Leg Pain
- Leg Cramps
- Pins & needles in Legs
- Knee Trouble
- Foot Trouble
- Pins & needles in Feet
- Ankle Pain

For women: Are you taking birth control? Yes No Are you pregnant? Yes No Not sure

Are you nursing? Yes No

Are you experiencing menopausal symptoms? Yes No If yes, please describe

Are you experiencing any breast soreness/lumps? Yes No