San Diego Spine and Sports Wellness

Please Print Below

Date_____

Patient Name_____ SS#_____

Address_____ Apt#_____City_____

State_____ Zip Code_____ Birth Date _____/_____/_____ Age_____

Circle one: Marital Status: S / M / D / W Male or Female

Spouses Name_____Spouse's Occupation_____

Spouse's Employer_____ Spouse's # (_____)_____

How did you find us?Please Specify_____

Your Occupation_____ Length at this job_____

Employer's Name &
Address_____

***Please Note the Following Email and Phone contact information MUST be filled out and are used for scheduling purposes.**

Home Phone (_____)_____Work Phone (_____)_____

Cell Phone (_____)_____
Phone Carrier (required for appointment reminders)_____

E-Mail_____

Are E-mail or Text Appointment Reminders Okay? YES or NO

Medical Physician's Name _____

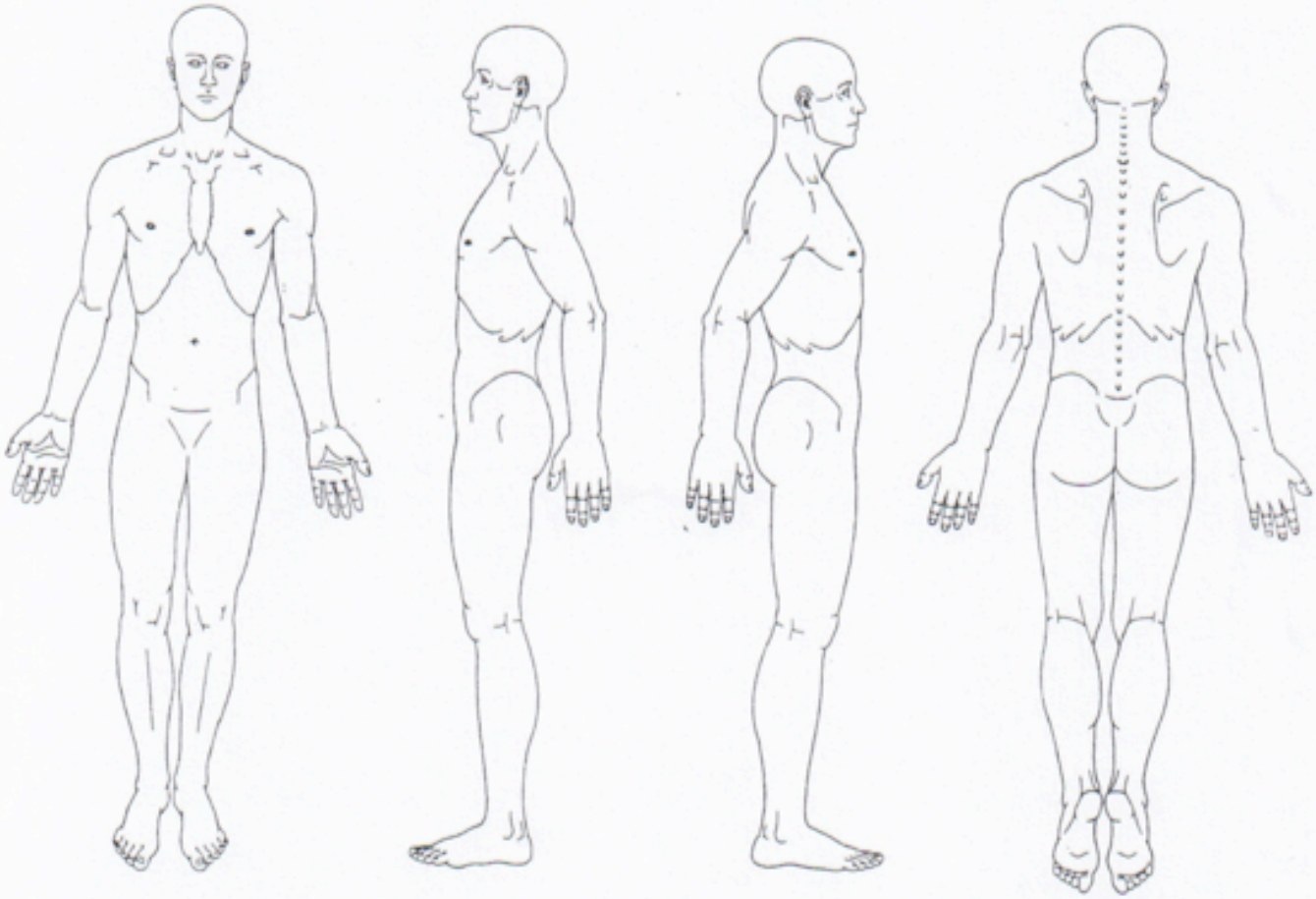
Address_____

If the patient is a **minor**, permission is hereby given to the doctors in this office to perform an examination as well as the treatment(s)I am his/her legal guardian

Parent Signature:_____

Using the following descriptive symbols, draw the location of your pain on body outlines below.
In addition, mark the level of your pain on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	========	OOOOOOOO	. . . . .	//////////	XXXX
^^^	=======	OOOOOOO	. . . . .	///////	XXX



No Pain — Worst Possible Pain

Please make a slash through this line as to the level of your pain.

Patient Signature

Please answer all of the following to the best of your ability
Please print clearly

What is your major complaint?_____
_____

How long have you had this problem?_____
Describe what you feel is the cause of your complaint:
_____
_____
Is your problem from an AUTO RELATED ACCIDENT or WORK INJURY (Please Circle)
If Circled above,
Date & Time of injury: DATE_____ TIME_____ LOCATION_____
If car accident: were you the DRIVER/PASSENGER in the FRONT/BACK/PEDESTRIAN?(Circle one)
Are you working Currently? YES or NO
How long have you worked at current job?_____ Full or Part Time (Circle)
Last Date Worked:_____
To Whom was the accident Reported if at work (ex. Supervisor)_____
Did you report this accident to insurance? YES or NO
How does your problem/condition effect your job(Please explain)_____
_____

Have you been treated by another doctor for this? YES or NO
Name of Doctor_____Specialty_____
Treatment _____
Special tests (X-rays,etc)_____
Results of tests?_____

Is your condition getting: (Circle one) Worse? Better? Same?
Have you done anything for the injury at home?_____
Have you had similar complaints prior to injury? YES or NO
Have you noticed any activity restrictions due to the injury? If so list them_____
_____
Has condition affected sleeping patterns?_____
What makes it worse?_____
What makes it better?_____

Any other body area that causes you pain? YES or NO If yes, where and explain briefly_____

Have you had a previous motor vehicle accident or injury? YES or NO (circle one) If so, explain,_____
_____

Previous Medical History

Smoker? YES/NO Packs/Day_____ Alcohol intake? **Yes/No** If yes, how much/week_____

Are you or is there a possibility that you may be pregnant?_____
Describe all surgeries:_____
_____
_____

Describe all fractures:_____

Describe additional medical problems(Diabetes, Kidney, Heart, etc.)_____
_____
_____

Describe all hospitalizations:_____
_____

Please list all medications and/or pills you take:

_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had any of the following tests performed?
MRI, CAT SCAN, X-RAYS, EMG/NCV, MYELOGRAM, PAIN INJECTIONS

Have you ever been diagnosed or suspected of having cancer?_____
_____

PLEASE CHECK OFF ALL CONDITIONS THAT YOU MAY HAVE CURRENTLY OR HAVE HAD IN THE PAST

- ❑Allergies
- ❑Anemia
- ❑Arm/Shoulder Pain
- ❑Arthritis
- ❑Asthma/Difficulty breathing
- ❑Bladder infections
- ❑Buzzing/Ringing Ears
- ❑Cancer
- ❑Chest Pain/Heart Trouble
- ❑Cold, Tingling Extremities
- ❑Concentration Loss
- ❑Constipation/Diarrhea/Colon
- ❑Cold Sweats
- ❑Depression
- ❑Diabetes
- ❑Disc Problems
- ❑Dizziness
- ❑ Ear Infections
- ❑ Fainting
- ❑ Fatigue
- ❑Fever
- ❑ Gallbladder
- ❑ Head Seems Heavy
- ❑ Headaches/Migraines
- ❑ Hepatitis/Liver
- ❑ Hip Pain
- ❑ Indigestion/Sleeping problems
- ❑ Joint Pain
- ❑ Kidney Problems
- ❑ Kidney Problems
- ❑ Light Sensitivity
- ❑ Loss of energy
- ❑ Loss of memory
- ❑ Loss of taste/smell
- ❑ Lower back pain
- ❑ Menstrual Pain/Cramps
- ❑ Mid-back pain
- ❑ Neck Pain
- ❑ Nervousness
- ❑ Pain in legs
- ❑ Pinched Nerve
- ❑ Poor Circulation
- ❑ Poor Posture
- ❑ Scoliosis
- ❑ Sinus
- ❑ Stress/Tension
- ❑ Tight Muscles
- ❑ Tuberculosis
- ❑ Venereal disease
- ❑ Vision Blurred
- ❑ Weight Loss
- ❑
- ❑
- ❑ Other_____

Waiver of X-Rays & Diagnostic Testing

This is to acknowledge that:_____Josh Jagoda_____DC, CCSP has recommended that X-RAYS and other diagnostic testing be taken so that a complete study and analysis may be made of my present problem (or illness).

I do not feel that my present problem (or illness) is serious enough to warrant the use of X-RAYS or other diagnostic testing, so that a complete study and analysis may be made by you. Therefore, you are hereby authorized and directed to treat my present problem (or illness) to the best of your ability without making a complete study and analysis of my present problem (or illness).

Should any untoward effects or any further illness or injury develop, directly or indirectly, as a result of such treatment, I shall assume full responsibility. In consideration of your treating me at my request without benefit of a complete study and analysis. I do hereby release you from all causes of action, damages, and liabilities arising by reason of said treatment, whether heretofore or hereafter occurring, and whether now known or unknown by the parties here to.

Date:_____Signature:_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy/physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am informed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns from heat lamps, ice or heating devices, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME: Dr Joshua Jagoda

(Date)

PATIENT SIGNATURE ✕

(Or Patient Guardian/Parent/Representative) (Provide name and relationship if signing for patient)