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 _____

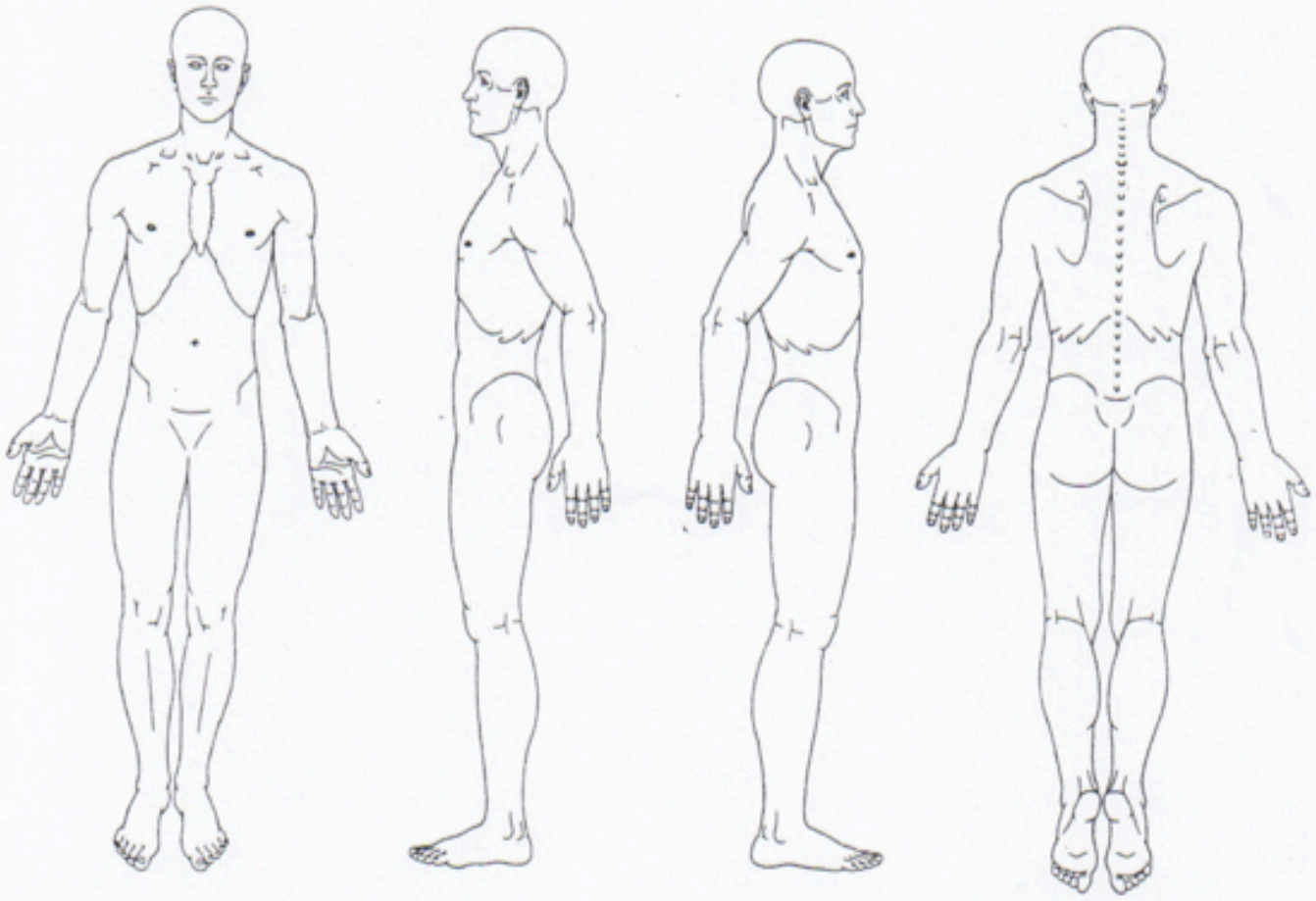
Address_____

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:
_____
_____
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:_____

PATIENT NAME:

# ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provideds clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here._____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE X

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

# 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:

(Date)

PATIENT SIGNATURE X

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