1125 East 16th Street, Suite 4
Upland, CA 91784
Phone: (909) 297-3531
Fax: (909) 297-3004

PATIENT INFORMATION

(   ) Cash   (   ) Health Insurance   (   )Personal Injury   (   ) Other

PATIENT NAME: ________________________________   DOB: ___/___/____   Age: _____

ADDRESS: ____   **MALE / FEMALE**
Street   Apt #

____
City   State   Zip Code

Cell: (   ) __________________   H Phone: (   ) _______________   Email: _________________________
Best reached by EMAIL / PHONE / TEXT

DRIVER'S LICENSE #: ____________________________   SOCIAL SECURITY #: ______ - _____ - ______

MARITAL STATUS: Single   Married   Divorced/Separated   Widowed
Spouse's Name: ____________________________

Work Status: EMPLOYED   RETIRED   DISABLED   F/TIME STUDENT   P/TIME STUDENT
Employer: __________________________   Occupation: ________________________   How long? ______
Employer Address: ____
____   Work phone: (   ) ___________________

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? ____
Relation: ____________________________   Phone: (   ) _______________   Other: ___________________

PRIMARY HEALTH INSURANCE INFORMATION   **PPO / HMO / EPO / OTHER**
Company Name: ____________________________________   ID#: _____________________________
Address: Phone#:
Insured's Name: ________________________________   Relation: ___________________   DOB: _____________
Insured's SSN: __________ -________-____________   Insured's Employer: ____________________________

Secondary/Spouse's Health Information: ____
____

Ever been treated by a chiropractor/acupuncturist before?   **YES/NO**   Date: ___/___/______
Referred by: _______________________________________

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due. ___________

MINORS - CONSENT FOR TREATMENT

I hereby authorize the staff at Upland Spine & Rehabilitation to administer chiropractic and/or acupuncture care as they deem necessary to my son/daughter, _________________________.

____
Parent/Legal Guardian Name   Signature   Date

____
Print Name   Signature   Today's Date

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Name: ______________________________________ Date: __________________________

Please describe the reason for this visit:

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Mark which sensation is most appropriate on diagram:

XXX Sharp, stabbing pain
OOO Shooting pain
NNN Numbness, tingling
SSS Sore, dull, achy

(Please use back of page if more room is needed)

How long have you had these symptoms? ________________________
Is this condition getting BETTER WORSE NO CHANGE
Please check any that apply: ___ PINS/NEEDLES ___ TINGLING ___ NUMBNESS ___ OTHER
Have you seen any other doctors for this condition? YES/NO
(If so, please include doctor, dates, diagnosis, treatment received and any residuals you still suffer from)

Date of last physical: ________/_______/___________ Date of last menstrual cycle: ______/_______/_______
Do you believe you may be pregnant? YES/NO
Do you have any infectious disease? YES/NO If yes, please identify _____________________________

Have you had any surgeries? YES/NO
Describe and date:

Have you recently been hospitalized for any reason? YES/NO
Describe and date:

Have you been involved in any recent accidents or trauma? YES/NO
Describe and date:

Please list all conditions/medications for which you are being treated by other physicians:

Medication/Reason:	Dosage:	Duration:

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For the following conditions, ***circle*** if you currently have or ***check next to*** if you previously had:

General:
Alcoholism
Anemia
Cancer
High Cholesterol
Diabetes
Epilepsy/Seizures
Thyroid
Anxiety
Gout
Hypoglycemia
Multiple Sclerosis
Osteoarthritis
Parkinson's Disease
Pneumonia
Polio
Rheumatic Fever
Rheumatoid Arthritis
Depression
Tuberculosis
Ulcers
Venereal Disease
Skin Problems

Cardiovascular:
Pain over heart
Heart attack
Swelling in ankles
Irregular heartbeat
Stroke
Shortness of breath on exertion
Low blood pressure
High blood pressure
Pressure over chest

Resistance to Infection:
Catch colds easily
Frequent sinus trouble
Frequent influenza/colds

Neuromusculoskeletal:
Headaches
Neck pain
Low back pain
Upper extremity pain
Lower extremity pain
Tingling in hands and feet

Nervous System:
Dizziness/lightheadedness
Discoordination
Fainting
Memory loss
Difficult speech

Respiratory:
Chest pain
Coughing blood
Difficulty breathing
Shortness of breath
Allergies
Chronic couch
Spitting up phlegm
Emphysema
Asthma

Urinary Tract:
Blood in urine
Inability to control urination
Painful urination
Bladder infection
Kidney stones

Men's Health:
Burning on urination
Prostate trouble
Feeling of incomplete bowel evacuation
Need to get up at night to urinate
Difficulty starting urination
Dripping after urination
Last prostate exam: ______________________

Gastrointestinal:
Gall bladder problem
Liver trouble/hepatitis
Excessive thirst
Distress from greasy foods
Pain over the stomach
Heartburn
Burning in stomach
Burping/bloating
Nausea
Diarrhea
Blood in stool
Metallic taste in mouth
Mucus in stool
Colitis
Hiatal hernia
Vomiting
Constipation
Recent weight gain
Recent weight loss

Women's Health:
Irregular periods
Hot flashes
Vaginal discharge
Menopausal symptoms
Headaches with period
Menstrual cramps
Excessive flow
Hysterectomy
Pre-menstrual depression
Painful breasts
Lumps in breasts
Breast surgery
Last Mammogram: ______________
Last PAP: __________________

FAMILY HISTORY

Do any of your family members have/ever had a history of the following conditions? If so, please indicate who:

___ High Blood Pressure
___ High Cholesterol
___ Stroke
___ Heart Disease
___ Seizure
___ Allergies
___ Arthritis
___ Asthma
___ Alcoholism
___ Cancer
___ Neurological Disorders
___ Autoimmune disorders
___ Kidney Disease
___ Diabetes
___ Other

Upland Spine & Rehabilitation Chiropractic Center

INFORMED CONSENT / PATIENT INFO FOR CHIROPRACTIC & ACUPUNCTURE TREATMENT

I, the undersigned, as a patient of the Upland Spine & Rehabilitation Center (Upland Spine), understand that the form of care is based on Chiropractic and/or Acupuncture and Oriental Medicine (AOM) principles and practices. I request and consent to the performance of chiropractic adjustments and AOM treatment which include but are not limited to physiotherapy, other forms of manual therapy, tui na, gua sha (dermal friction), cupping, electro-acupuncture, moxibustion and infrared/thermotherapy.

I will inform my chiropractic doctor/acupuncturist of all my health concerns, allergies, medications, supplements and medical interventions because safe care requires that I truthfully and completely disclose this information. I will inform my chiropractor/acupuncturist if I am (have the possibility of being) pregnant and/or breastfeeding, have bleeding disorders, pacemakers and/or surgical hardware prior to receiving treatment.

I understand chiropractic and AOM provide relief from pain and presenting symptoms without the use of drugs or medication. Although chiropractic and/or acupuncture treatments are generally safe and gentle, there are certain, very infrequent, complications, which may arise during and/or after the visit. These risks include but are not limited to soreness, sprains/strains, fractures, dislocations, aggravation of disc injuries, cerebral vascular accidents, soft tissue injuries; localized bruising, blistering, swelling, bleeding or infection at the site of the needle; discomfort during and after inserting the needle; dizziness, fainting, nausea; minor burns; a broken needle; allergic reaction to Chinese herbs; possible aggravation of symptoms that existed prior to treatment. These complications are extremely rare occurrences.

I understand that my chiropractor/acupuncturist will explain to me the exact nature of any treatment provided. I understand that Upland Spine does not promise a cure for any symptom, disease or condition as a result of treatment. I do not expect Upland Spine to be able to anticipate and explain every risk or potential complication of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures that they feel at the time to be in my best interest.

As a patient of Upland Spine, I understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative courses of action. I am always at liberty to seek or continue care from another qualified healthcare provider, but at this time, I choose chiropractic/AOM.

I understand the cancellation policy requires me to cancel a booked appointment 24 hours prior to that appointment. If I fail to do so, a cancellation fee of $35 will be charged. I accept full responsibility for any fees incurred during care and treatment. In instances of repeated non-compliance, Upland Spine reserves the right to discontinue care.

My signature on this form indicates that I have read and understand the preceding information and policies. I understand that if I have any questions about this information, I should ask my chiropractor/acupuncturist. I am comfortable with the information provided and voluntarily consent to chiropractic and/or acupuncture treatment and management on that basis. I hereby release the Upland Spine & Rehabilitation Chiropractic Center and its staff from any and all liability, which may occur in connection with the above mentioned procedures. I understand that I am free to discontinue participation in these procedures at any time.

____

Patient (Parent/Legal Guardian) Name		Signature		Date

____

Doctor Signature		Date