WILLIAM W. JACOBSON II, D.C.
Chiropractor
446 North Craig Avenue
Pasadena, CA 91107-2460
(626) 793-1633

Dear New Patient,

I look forward to us meeting soon. Please fill in the following pages prior to your appointment so that we can make the best use of the time we have together. Please don't forget to draw on the diagram on the second page.

We will discuss the consent to treat form when we meet at your appointment. If you were involved in an auto accident please download and fill out the auto accident forms as well.

Should you have any questions I can be reached at 626-793-1633.

Until we meet,

Dr. Jacobson

Referred to this office by: _____

New Patient Personal History

Today's Date _____ Social Security # _____ Birth date _____ Age _____

Name _____ Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Occupation _____ Driver's License _____

Employer & Address _____ Work Phone _____

Check One ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated # of Children _____

Name of Spouse _____

Spouse's Birth date _____ Spouse's Social Security # _____

Spouse's Employer & Address _____

Spouse's Work Phone _____ Spouse's Cell Phone _____

Name of Emergency Contact _____

Address _____ Phone _____

When did you first notice this condition? _____ Has it happened before? _____

Did it appear: Immediately Slowly: ( ) weeks ( ) months ( ) years

What aggravates your present condition? ☐ Prolonged Sitting ☐ Standing ☐ Walking ☐ Running

☐ Driving ☐ Other-Explain: _____

Does any position relieve the pain? _____

What other health care providers have you seen for this condition? _____

What medications have you taken for this condition? _____

Have you had previous neck or back injuries? (List date & severity, i.e. Auto, W/C, trauma, other) _____

Job Description & Home Environment (Activities) _____

Who is responsible for your bill? ☐ Self ☐ HMO/PPO ☐ Other: _____

☐ Worker's Compensation ☐ Auto Ins ☐ Medicare ☐ Group Insurance

If **INSURANCE**, please fill in below and present all ID cards.

Primary Insurance Company _____ Group. # _____

2nd Insurance Company _____ Group.# _____

Worker's Compensation Insurance _____ Claim# _____

If **WORK RELATED INJURY**, who did you report the injury to at work? _____

Have you made a written report of your injury to your employer? ☐ Yes ☐ No DWC-1 Filed? ☐ Yes ☐ No

ACCIDENT Date _____ ☐ Work Comp ☐ Auto Accident

Your Automobile Insurance _____

Phone _____ Policy/Claim # _____

Attorney _____ Phone _____

Address _____

If this is an accident related injury, you must fill out the Accident Form. **THANK YOU!**

Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ I want the Doctor to select the type of care desired that we may be guided by your wishes

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I authorize the Doctor's office to prepare any necessary reports and forms to assist me in making collection from the insurance company and I agree the amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature X _____ **Date** _____

IMPORTANT: Please **X** all current symptoms.

HEAD:
- ☐ Headache
  - ☐ Sinus (allergy)
  - ☐ Entire Head
  - ☐ Back of Head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
- ☐ Head Feels Heavy
- ☐ Loss of Memory
- ☐ Light-headiness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears
- ☐ Clench your teeth
- ☐ Grind your teeth
- ☐ Jaw clicks
- ☐ Jaw gets stuck open

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)

Can't raise arm:
- ☐ above shoulder level
- ☐ overhead

- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Pins/needles in arms
- ☐ Pins/needles in fingers
- ☐ Numbness in arms (R-L)
- ☐ Numbness in fingers (R-L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

LOW BACK:
- ☐ Low back pain

Low back pain is worse when:
- ☐ Working
- ☐ Lifting
- ☐ Standing
- ☐ Sitting
- ☐ Bending
- ☐ Coughing
- ☐ Lying down
- ☐ Walking

- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis
- ☐ Pain is relieved when:

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip (R-L)
- ☐ Pain down leg (R-L)
- ☐ Knee pain (R-L)
  - ☐ Inside ☐ Outside
- ☐ Leg cramps (R-L)
- ☐ Cramps in feet (R-L)
- ☐ Pins/needles in legs (R-L)
- ☐ Numbness in legs (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes (R-L)
- ☐ Feet feel cold (R-L)
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)

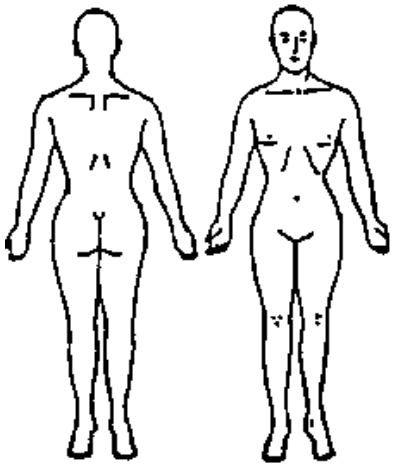
CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods you can't eat: _____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Urinary frequency
- ☐ Difficulty starting
- ☐ Frequency of nighttime urination
- ☐ Prostate pain/swelling

WOMEN ONLY:
- ☐ Menstrual pain (where) _____
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle (days) _____
- ☐ Birth control (type) _____
- ☐ Hysterectomy
- ☐ Genital cancer (type) _____
- ☐ Discharge
- ☐ Menopause (when) _____
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you might be pregnant?

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigued
- ☐ Generally feel run-down
- ☐ Normal sleep(hrs/night) ____
- ☐ Loss of sleep(hrs/night) ____
- ☐ Loss of weight(lbs) _____
- ☐ Gain of weight (lbs) _____
- ☐ Coffee (cups/day) _____
- ☐ Tea (cups/day) _____
- ☐ Cola drinks(oz/day) _____
- ☐ Cigarettes (pack/day) _____
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Broken bones
- ☐ Other _____

Diagram Areas of Concern



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INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including but not limited to various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for or in consultation with the doctor of chiropractic named above, including those working at the clinic or office listed below or any other office, hospital or clinic.

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

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, disk 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 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name _____ Signature of Patient _____
PLEASE PRINT

Date Signed _____ Witness to Patient's Signature _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE
IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient Name _____ Name of Representative _____
PLEASE PRINT PLEASE PRINT

Date Signed _____ Signature of Representative _____

Relationship or Authority of Patient's Representative _____

DIAGNOSTIC TESTS AND OR X-RAY WAIVER

Patient Name: _____
PLEASE PRINT

This written letter will confirm that diagnostic tests and/or x-rays have been recommended to me by my doctor of chiropractic. Nevertheless, I choose not to have these tests performed and therefore I do release and forever discharge William W. Jacobson II, D.C. from any responsibility or liability relating to any injury that may arise out of my present condition or health involvement, since my doctor will be unable to properly analyze my problem and care for it without the benefit of these tests. I further wish to attest to the fact that this Waiver is given voluntarily and I understand that by signing this form, I am waiving certain rights which I might have had in the event that my problem in not corrected or stabilized. Nevertheless, I choose this Waiver knowing that my health may be in jeopardized due to my decision.

Date _____ Signature _____

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason: