Kalani
TOTAL HEALTH CENTER

2901 N. Ventura Road, Ste. 220 Oxnard, CA 93036
Phone: 805.604.0881 Fax: 805.604.0883

CONFIDENTIAL PATIENT INFORMATION

Date:_____

Name: _____ Home Phone:_____
Address: _____ Work Phone: _____
City & State: _____ Zip: _____ Cell Phone: _____
SS#: _____ E-Mail Address: _____
Occupation: _____ Employer: _____
Work Address: _____ City& State: _____ Zip: _____
Birth Date: _____ Age: _____ Sex: **M F** Marital Status: **S M W D**
Spouse's Name & Age: _____
Names of Children & Ages: _____
How were you referred to our office? _____
Have you ever been to a chiropractor before? _____ If so, when? _____
Circle your complaints and write how long you have had it.

Neck Pain/Stiffness	_____	Rib Problems	_____
Headaches	_____	Low back Pain	_____
Shoulder Pain	_____	Hip/Groin Pain	_____
Arm/Hand Pain	_____	Leg Pain (R/L)	_____
High/Low Blood Pressure	_____	Dizziness	_____
Allergies	_____	Upper/Mid Back Pain	_____

What type of care have you already received for your condition?
Chiropractic ____ Massage ____ Medication ____ Surgery ____ Other _____

Name of Doctor(s) who have cared for you: _____
Circle any conditions you have currently or previously had.

AIDS/HIV	Arthritis	Asthma	Anemia	Anorexia
Appendicitis	Bulimia	Cancer	Bleeding	Breast Lump
Bronchitis	Diabetes	Emphysema	Cataracts	Chemical Dependant
Chicken Pox	Goiter	Gonorrhea	Epilepsy	Fractures
Glaucoma	Hernia	Herniated Disc	Gout	Heart Disease
Hepatitis	Liver Disease	Measles	Herpes	High Cholesterol
Kidney Disease	MS	Mumps	Osteoporosis	Miscarriage
Mono	Pinched Nerve	Pneumonia	Polio	Pacemaker
Parkinson's	Psychiatric Care	Rheumatoid Arthritis	Rheumatic Fever	Prostate Problem
Stroke	Suicide Attempt	Thyroid Problems	Tonsillitis	Scarlet Fever
Tumors, growths	Typhoid Fever	Ulcers	Vaginal Infections	Vision Problems
Fibromyalgia	Migraine	Cold/Flu	Viral Infections	TB
Whooping Cough	Vision Problems	Ear Infections	Other _____	

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Informed Consent to Chiropractic Care

***Patient**: Please discuss any questions or concerns with the doctor before signing this consent.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by Dr. Kalani G. Jose, his staff, and/or his associates.

The Nature of the Chiropractic Adjustment

I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "pop" your knuckles. You may feel a sense of movement.

The Material Risks Inherent with the Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, we look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as "rare".

Ancillary Treatment

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

Heat ~ risk of 1st and 2nd degree burns, hemorrhage
Cryotherapy (cold packs) ~ risk of skin reactions
Trigger Point Therapy ~ risk of bruising, release of emboli
Massage ~ risk of deep vein thrombosis

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

Self-administered over-the-counter analgesics and rest
Medical care with prescription drugs
Hospitalization
Surgery

The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:

Overuse of over-the-counter medications produces undesirable side effects. If complete rest in impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

_____

Date:

_____ _____

Printed Name of Patient Signature of Patient

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PERSONAL INJURY ACCIDENT HISTORY

Date of accident: _____ **Time of accident:** _____ **am/pm**

Name: _____
(last) (middle) (first)

What type of claim?

Automobile Motorcycle Slip and Fall Other

Driver / Passenger Minor / High Impact Collision

Are you represented by an attorney? Yes / No

Attorney's Name & address (if any):_____
_____
_____
Attorney's Phone #: (___)_____

Your current insurance information: ACCIDENT INFORMATION

Insurance Carrier: _____

Address: _____

Claims Adjuster's name: _____ Tel. #: ( )_____

Policy #: _____ *AND* Claim #: _____

OR Responsible Party's name: _____

Tel #: ( ) _____ Their Insurance Carrier: _____

Their policy #: _____ Claim #: _____

Claims Adjuster's name: _____

YOUR VEHICLE

Vehicle condition: **Damage amount**: $_____ **Damage** ------- Mild -------- Severe

Was your vehicle totaled? Yes / No

Your position in the vehicle:

------ Driver ------ Passenger **Circle one location:** Front Passenger/ Rear Passenger/ 3rd Seat (rear)/ left middle/ right

Speed of your vehicle:

------ Complete stop ------ Moving moderately ---------- Slowing ---------- Moving approx. ---------- mph

------ Parked ------ Moving fast -------- Moving slowly

Collision Type:

------ Driver's side impact ------ Head on collision ------Passenger's side impact

------ Rear impact ------ Front impact ----- Pedestrian incident

Briefly Describe the Accident:

_____
_____
_____
_____
_____

Other Vehicle

Vehicle type:

------ Car

------ Van

------ Station Wagon -------- Other

Vehicle condition:

Was the vehicle totaled? Yes / No

Damage ------- Mild -------- Severe

Speed of the other vehicle: _____mph

The Following Questions Concern The Moment Of The Impact Of The Accident:

Restraints: (check all that apply)

------ Seatbelt ------ No restraints --------- Child Car seat

Was the airbag deployed? ------Yes ------ No ***OR*** ------ Car was not equipped with airbags

Was your head thrown?

------ Backward & then forward ------ Forward then backward

------ To the left then to the right ------ To the right then to the left

Was your body thrown?

------ Backward & then forward ------ Across the vehicle

------ Forward then backward ------- Outside the vehicle

------ To the left ------ To the right ------- Under the vehicle

------ To the left then right/left ------- To the right then left/right

As A Result Of The Force Of The Collision, Which Objects In The Vehicle Did Your Body Strike?

Head **Torso** **Left Arm** **Right Arm**

Left or right hips **Left leg/knee** **Right leg/knee**

Steering wheel Armrest Console Dashboard Windshield
Headrest Door Window

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

------ Yes ------ No

Immediately following the accident, did you feel?

------ Dizzy ------Weak ------Dazed

------ Nervous ------ Disoriented ------ Nauseated

Were you able to leave your vehicle Without help?

------ Yes ------ No

Was the police notified? Yes / No
Was a report taken? Yes / No
Did the paramedics arrive? Yes/No

Where did you go after the accident?

------ Drove home ------Drove to work

------ Was driven home ------ Was driven to work

------ Hospital ------- Was driven to hospital by whom?

-------- By ambulance

If you sought treatment, please list the date and name of the facility/ies

Date and name of doctors / hospitals/ medical facilities you received treatment for this accident:

Date: _____ Name of facility: _____

Date: _____ Name of facility: _____

Date: _____ Name of facility: _____

Were you prescribed any medication(s)? Yes / No What type: _____

Any x-rays taken: Yes / No What area(s): _____

Are you currently working? Yes / No **Have you lost time from work since the accident?** Yes / No **Hour/s lost:** _____

Day/s lost: _____

Are you a student? Yes / No **Have you lost time from school since the accident?** Yes / No **Hour/s lost:** _____

Day/s lost: _____

Have you been able to perform your regular job duties? Yes / No

Please state the month and year, a brief description for the following:

Date: ____/____ Illnesses? _____

Date: ____/____ Previous injuries? _____

Date: ____/____ Surgeries? _____

Date: ____/____ Fractures/Broken bones? _____

Next day discomfort?

------ increased ----- decreased

------ same

Did your major complaints exist before the accident?

------ Yes ------ No

In what area did you IMMEDIATELY feel pain?

Head Neck Upper Back Mid Back Low Back Hip Ribs Chest

Abdomen Shoulder Arm Elbow Wrist Hand Fingers Leg Knee

Ankle Toe

Any Specific Side? Right or Left or Both
If multiple sides, please explain

_____
_____
_____

In what area did you experience lacerations (cuts) or bruises?

_____
_____

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NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME_____ DATE _____

For any YES answer, please explain under comment and notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Have you tried any medications such as anti-inflammatory? NO YES
    If YES, what kind of medication: _____
    _____
12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If YES, When? For how long? What kind? _____
    _____
13. Have you had an MRI? NO YES
    If YES: When? Who ordered it? What was it ordered for? _____
    _____
14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If YES: When? What kind? Who ordered it?
    _____
15. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: _____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.