Rambod Derakhshani DC FIAMA

Today's date: ____ /____ /_____

About You

First Name: ____________________________________ MI: __________
Last Name: _____________________________________ [ ] Male [ ] Female
SS #: _______________________________ Birthdate: _______/_______/_______ Age: ________
Email address:______________________________
Address: ____ Apt: ________ City: _________________________ State: _________ Zip: ______________
Home #: _________________________________ Cell #: ________________________________ Wk #: ____________________________ Ext: _________
Occupation: _______________________________________ Employer: ______________________
Marital Status: S M D W
# of children: ______________ Spouse's Name: ___________________________________
(if minor) Parent or Guardian: ____________________________

Who may we thank for referring you to our office:
____

Insurance Information: *We will make a copy of your insurance card(s). However, please complete the following information.*

Are you the policyholder? **Y N**
Insurance Name: ______________________ Policyholder's Name: _________________________
Birthdate: _______/______/_____ Male/ Female
Policyholder's SS #: ________________________ Address: ___________________________________
Employer: ________________________
Member ID#:_________________________________ Group #:_________________________________

Do you have secondary insurance coverage: Y N If **YES**, please complete this section.
Insurance Name: ______________________ Policyholder's Name: _________________________
Birthdate: _______/______/_____ Male/ Female
Policyholder's SS #: ________________________ Address: ___________________________________
Employer: ________________________

Reason For Visit

Please describe the pain & its location: ____
The pain is a result of: ____________________
When did the pain begin?: _________________________ Is the pain getting worse?: [ ] **Yes** [ ] **No**

Is your pain present constantly / 50-100% of time / 25-50% of time / 0-25% of awake time?

Rate your Pain 0 1 2 3 4 5 6 7 8 9 10 (0 being no pain and 10 being excrutiating)

Does your pain keep you awake at night Yes No or wake you up from sleep? Yes NO

Have you had this or a similar conditions in the past: [ ] **Yes** [ ] **No** If **YES**, explain:
____
Have you been treated by another physician for this condition? [ ] **Yes** [ ] **No** If **YES**, explain
____
Have you ever been treated by a chiropractor before:? [ ] **Yes** [ ] **No**
Name of your family doctor: _________________________________
Family Doctor's #:____

Health History

Habits: Cigarettes - [ ]**Yes** [ ] **No** Alcohol - [ ]**Yes** [ ] **No** Coffee - [ ]**Yes** [ ] **No** Exercise - [ ]**Yes** [ ] **No**
Are you pregnant: **Y** **N**
Weight________________ Height_______________ Waist____________________
Are you taking any medications? If **YES,** list:

Do you have or ever had any of the following conditions or diseases?
Y **N** Heart Attack/Stroke **Y** **N** Cancer **Y** **N** Diabetes **Y** **N** Tuberculosis
Y **N** Frequent Neck Pain
Y **N** Psychiatric problems **Y** **N** Difficulty breathing **Y** **N** Sever/frequent headaches **Y** **N** Sinus Problems
Y **N** Lower Back Problems **Y** **N** Fainting/seizures/epilepsy **Y** **N** Asthma
Y **N** Artificial bones/joints

Please list any other serious medical condition(s) you have or had:
____

List previous/past surgeries/treatments with dates:
____

Family History: (please circle) Headaches, Low Back Pain, Neck Pain, Other spinal problems, explain:
____

____

Assignment & Release

*I understand & agree that health & accident insurance policies are an agreement between an insurance carrier & myself. Furthermore, I understand that this office will prepare any necessary reports & forms to assist me in making collection from the carrier & that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt.
*As a courtesy to you we will verify your health care benefits for this office. You will then be responsible for any co pays and deductibles.
*Your health insurance is a contract between you & the insurance carrier. In the "rare" event that your insurance company is in "bad faith" & after our office make every attempt to have all claims paid, we will have you, the patient, be responsible for contacting your insurance carrier to have the claims paid.
*If your insurance company has not paid within 120 days of billing, then you will be responsible to pay the balance due.
*If Collection efforts become necessary to enforce payment terms, the patient agrees to pay all collection costs, attorney's fees, & other costs associated with collecting this balance.
*I hereby authorize & release the doctor & whomever he/she assistants, to administer treatment, physical examination, x-rays studies, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to an y person or corporation which is or may be liable under a contract to this office or to patient or to a family member or employer of the patient for all or part of the clinic's charge, including & not limited to hospital or medical services companies, worker's compensation carriers, welfare funds, or the patient's employer.

Signature ____
Date: __________/__________/__________

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Dr Derakshani,

I hereby request and consent to the performance of Chiropractic treatments (also known as chiropractic adjustments, chiropractic manipulative treatments) and any other associated procedures; physical examination, test, diagnostic x-rays, physiotherapy, acupuncture, physical medicine, physical therapy procedures, etc, on me by the Doctor of Chiropractic named above and / or other assistants and / or licensed practitioners.

I understand as with any health care procedures, that there are certain complications, which may arise during treatments. Those complications include but are not limited to; fracture, disk injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risk of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risk involved in chiropractic treatment at this office by Dr Derakhshani. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

X_______________________________

Printed name of patient

X_______________________________

Signature of patient or legal guardian

Date:________/_________/_________