Nepomnaschy Chiropractic Inc.
Dr. Eric Nepomnaschy, D.C.
2116 WILSHIRE BLVD. SUITE 208
SANTA MONICA, CA 90403
310-993-8482 p 310-998-8483 f

CONFIDENTIAL PATIENT CASE HISTORY (Case#_______________)

Doctor______________________

Date_________________________

Name (Last, First, M.I)____Preferred Name________________

Address____City_________________State____ Zip_________

Home Phone_____________________Work Phone__________________Cell Phone___________________________

If needed, the Doctor may call you at: Home Work Cell Either

E-mail______________________________Fax_________________Website_______________________________

Social Security Number____________________ Driver's License #__________________Referred by____________

Sex: M F Age_____ Date of Birth___________ Marital Status: M S W D How many children___ Ages__________

Employer____Occupation____________________________

Employer's Address____Phone_________________________

Who is responsible for your payment?_______________Are you insured? Yes Not Ins. Company___________

How much is your deductible?______________________Has your deductible been met this year? Yes No

How will you pay for care? Cash Check Visa Mastercard

Person to Contact in case of Emergency: Name_________________________________Phone__________________

Releationship____

Are you seeking Chiropractic Care for: ☐ Health Maintenance/Optimization ☐ Health Problems ☐ Both

My Health is: ☐ Always a top priority ☐ Low priority ☐ Only a priority when I'm sick

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How were you referred to our office?____

INITIAL CONSULTATION RECORD (Please Answer Completely)

Patient Name:____(Office Use Case #:__________)
Please List Reason/s for Visiting Our Office:____
____
When Did it Start:_________Has your complaint gotten Worse Improved or Stayed the Same since it started?(circle one)
How did it start: Fell/Trauma ☐ Work Related ☐ Auto Accident ☐ Sports Injury ☐ Other ☐

Explain:____

What treatment or activity make your complaint better?____

What treatment or activity make your complaint worse?____

Is the pain/complaint there all the time or does it come and go?____

Is your pain dull/achy or sharp-shooting?(circle all that apply) Does your pain travel/radiate from one area of the body to another? Yes/No where:_____________________ Do you feel any abnormal skin sensations such as numbess-tingling-pins and needles-burning? (circle all that apply) Where:_______________________For how long?________

Do you have any other complaints? If so explain: ____
____
____
____

MEDICAL HISTORY

Are you taking any medicine? (Either prescription or over the counter) If so what and how much?_________________________
____
Are you taking any supplements? Vitamins/Minerals? If so what and how much?___________________________________
____
Are you under the care of any other doctor? Yes__ No__ If so, what are you being treated for:__________________

Have you have any weight gain/loss in the last 6-12 months? How much: ___________ Gain or Loss (circle one)
List any past surgeries with dates:____
List any past hospitalizations with dates:____
List any past accidents with dates:____
List any x-rays, MRI or bone scan test you've had in the past 2 years:____
Have you ever had a broken bone? List all and explain how it was broken:______________________________________
FEMALES: Are you pregnant or is there a possibility that you might be pregnant? Yes______ No______
Do you smoke? Yes ☐ No ☐ Do you drink alcohol? Yes ☐ No ☐ How much: _____per Day/Week/Month
Have you or anyone one in your family ever suffered from any of the following conditions: ☐ Cancer ☐ Diabetes
☐ Hypertension ☐ Stroke ☐ Heart attack ☐ Multiple Sclerosis ☐ Tuberculosis ☐ Other:___________________

CHIROPRACTIC HISTORY

Have you ever been to a Chiropractor before? Yes ☐ No ☐
If yes, list Doctor's Name____City_______________________
How long since your last visit?_____________________ Reason for care?_________________________________
Please describe your results:____________________________________How long were you under care?___________
____

Exercise Habits: ☐ None ☐ Regular ☐ I was regular but not now ☐ Weekend Warrior ☐ Hobbies:_________
Work Activities: ☐ Mostly sitting ☐ some lifting ☐ bending ☐ standing ☐ driving ☐ twisting ☐ computer work
☐ repetitive motion ☐ heavy lifting ☐ toxic chemicals

Signature:____ Date:__________

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HEALTH QUESTIONAIRE:

For each of the questions below, please indicate whether or not your have experience persistent symptoms.

Codes: 1 for NEVER had; 2 for PREVIOUSLY had; 3 for CURRENTLY have.

MUSCULO-SKELETAL

___Low back problems
___Pain b'twn shoulders
___Back problems
___Arm problems
___Leg problems
___Swollen joints
___Painful joints
___Stiff joints
___Sore muscles
___Neck pain
___Walking problems
___Mid-back pain
___Broken bones
___Wrist pain
___ Headaches

URINARY SYSTEM

___Bladder trouble
___Excessive urination
___Scant urination
___Painful urination
___Discolored urine

FEMALE SYSTEM

___Vaginal discharge
___Vaginal bleeding
___Vaginal pain
___Breast pain
___Lumps on breast

GASTRO-INTESTINAL

___Poor appetite
___Excessive hunger
___Difficulty chewing
___Difficulty swallowing
___Excessive thirst
___Nausea
___Vomiting food
___Vomiting blood
___Abdominal pain
___Diarrhea
___Constipation
___Black stool
___Bloody stool
___Hemorrhoids
___Liver trouble
___Gall bladder probs.
___Weight trouble

NERVOUS SYSTEM

___Numbness
___Loss of feeling
___Paralysis
___Dizziness
___Fainting
___Muscle jerking
___Convulsions
___Forgetfulness
___Confusion
___Depression

CARDIO RESPIRATORY

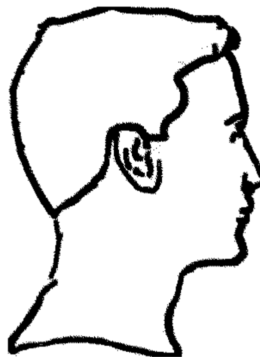
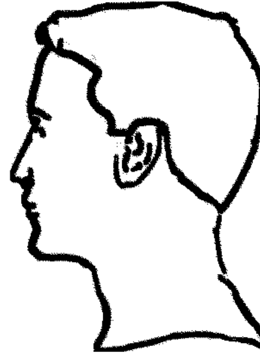
___Chest pain
___Pain over heart
___Difficult breathing
___Persistent cough
___Coughing phlegm
___Coughing blood
___Rapid heartbeat
___Blood pressure prob.
___Heart problems
___Lung problems
___Varicose veins

EYE, NOSE & THROAT

___Eye strain
___Eye inflammation
___Vision problems
___Ear pain
___Ear noises
___Hearing loss
___Ear discharge
___Nose pain
___Nasal bleeding
___Nasal discharge
___Difficult breathe by nose
___Sore gums
___Dental problems
___Sore mouth
___Hoarseness
___Difficulty speaking

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury of discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

OFFICE USE ONLY
Case: ____________
Date: ____________
Time: ____________

Nepomnaschy Chiropractic Inc.
Dr. Eric Nepomnaschy, D.C.

CONSENT TO TREATMENT

I ____________________________________, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the **safest** , most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. ________ **(Initial)**

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare**.**____ **(Initial)**

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution**.**_______ **(Initial)**

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. _____**(Initial)**

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits**.**____**(Initial)**

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. ____**(Initial)**

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

____ Signature of patient

____ Signature of witness

____ Date and time

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Office Policy: Financial Responsibility

Deductibles, nutritional supplements, orthotics and any non-covered insurance or private pay item/services are due in full at the time the service is rendered.

*Except in personal injury cases when all criteria has been satisfied to qualify you as a personal injury claim, either on a med-pay basis, as first priority or doctor/attorney lien approved by our office as a secondary basis. Doctors liens must be paid in full at the time of settlement of your case or one year from the date of treatment onset regardless if the case was settled or not. All services rendered by Dr. Eric Nepomnaschy, D,C. are charged directly to you, you are personally responsible for payment of these charges. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest and/or attorney fees and/or court costs will be added to the total amount due.

Your insurance company will be billed as a courtesy to you with the information provided by you. We may require your assistance in contacting your insurance company regarding the payment status if payment is not received after 30 days. It is your responsibility to understand and know your insurance policy benefits and that your treatment gets paid in full. If insurance payment is received by the patient, payment and explanation of benefits (EOB) is expected within five (5) days in order to properly credit your account.

By signing below, I give authorization to Nepomnaschy Chiropractic Inc. (Dr. Eric Nepomnaschy, D.C.) to sign on my behalf any insurance checks paid to you on my behalf.

Repeated no shows, or last minute cancellations may result in premature discharge of the patient (at doctor's discretion).

Nepomnaschy Chiropractic Inc. accepts cash, personal checks and Visa or Mastercard as forms of payment. There is a $**25.00** service charge for all returned checks.

There is an interest charge of 2% per month on all outstanding balances when there is no activity for 30 days. Interest will be added monthly thereafter until balance is paid in full. **Account must be paid in full within 3 months or account will be sent to collections.** Office discounts will not apply if sent to collections.

I have read and understand the above terms and conditions and by executing this document with my signature below, do hereby accept and agree to all of the terms and conditions outlined. An altered policy will not be accepted.

X____________________________________ X________________________
Signature of Patient or responsible party Date
Witness to signature____________________ X________________________
Patient File #: _________________________ Date