Personal Touch Chiropractic

NEW PATIENT INFORMATION FORM

Please print clearly:

Name: _____ Date: _____
Address: _____ Apt.# _____
City: _____ State: _____ ZIP _____
Shipping Address: _____
Home Phone (_____) _____ Work/Alt Phone (_____) _____
e-mail address: _____

REFERRED BY: _____
Occupation _____ Employer _____
Date of Birth _____ Age _____ Sex: M / F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____
Chief complaint (reason you are here): (use separate sheet if more room needed)

_____
Previous treatments for this complaint: _____

_____
Other complaints or problems: (use separate sheet if needed) _____

_____
Current medications/drugs being taken: (use separate sheet if needed) _____

_____
Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____
Nutritional supplements you are taking: _____
Do you smoke, drink coffee or alcohol? (if yes indicate how much)
Cigarettes_____ Coffee_____ Alcohol _____

HISTORY:

List any major illness (with approx. dates):

List any surgery or operations with approx. dates:

Past Accidents or injuries:

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Name: _____ Date: _____

Marital Status: S M D W Name of Spouse: _____

Describe health of spouse:_____ Number of children if any:____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any family history of serious illnesses (circle those who apply):
Cancer/ Diabetes/ Heart/ Other _____
Any household pets or other animals you or family members are in close contact with:
_____

What can we do to make you happier? _____
_____

SIGNED: DATE:

Office Use Only:

Personal Touch Chiropractic
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Los Angeles, CA 90045
Off. (323) 238-2260
Email: office@personaltouchchiro.com

Terms of Acceptance for Telewellness Services

When a client seeks nutritional services and we accept a client for such services, it is essential for both to be working towards the same objective.

The assessment of a client's wellness status is obtained by using various methods for gathering information by looking at a client's biochemical, structural, bioenergetics, mental and physical parameters. This may include, but may not be limited to the following: Systems Survey, Food Diary, Body Composition, Physical Measurements, Physical Tests, Blood Labs, etc.

We believe that health is a state of optimal physical, mental, and social well-being and not merely the absence of disease. Your wellness program is a regimen of recommended action steps to undertake that includes, and is not limited to the following: dietary improvements, whole food nutritional supplementation, keeping a diet record to record improvements, starting/upgrading daily exercise, detoxifying the body, and proper mental attitude, all to reduce the stress response on the body, and thereby promote maximum function in the mind-body and best possible social interaction.

We do not offer to diagnose or treat any disease or condition. We offer you information about the state of function of your body and possible ways of improving its biochemistry for the purpose of living a more balanced, healthful and wellness - oriented lifestyle. However, if during the course of our analysis of your case we encounter findings that are outside of our scope or expertise, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in the area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY OBJECTIVE is to improve your biochemistry through the use of improved nutrition and offer suggestions that would help you live a more balanced and healthful life.

It is very important that you are punctual for your scheduled **phone/zoom consultations**, and that any and all paperwork is completed before your scheduled consultation time. If you need to cancel and appointment, please do so 24 hours prior to our phone call. Missed scheduled appointments will result in **a $25 fee**.

I _____, have read and fully understand the above statement. All questions regarding our objectives pertaining to my participation in my own wellness care decisions have been answered to my complete satisfaction. I therefore agree to participate on this basis.

Sign_____ Date_____