

Carlsbad Chiropractic

Name _____ Date _____

In the drawing below please indicate where you are experiencing pain by drawing in the letter abbreviation (s) on the diagram that most accurately reflects the type of discomfort that you have experiencing.

Numbness = N

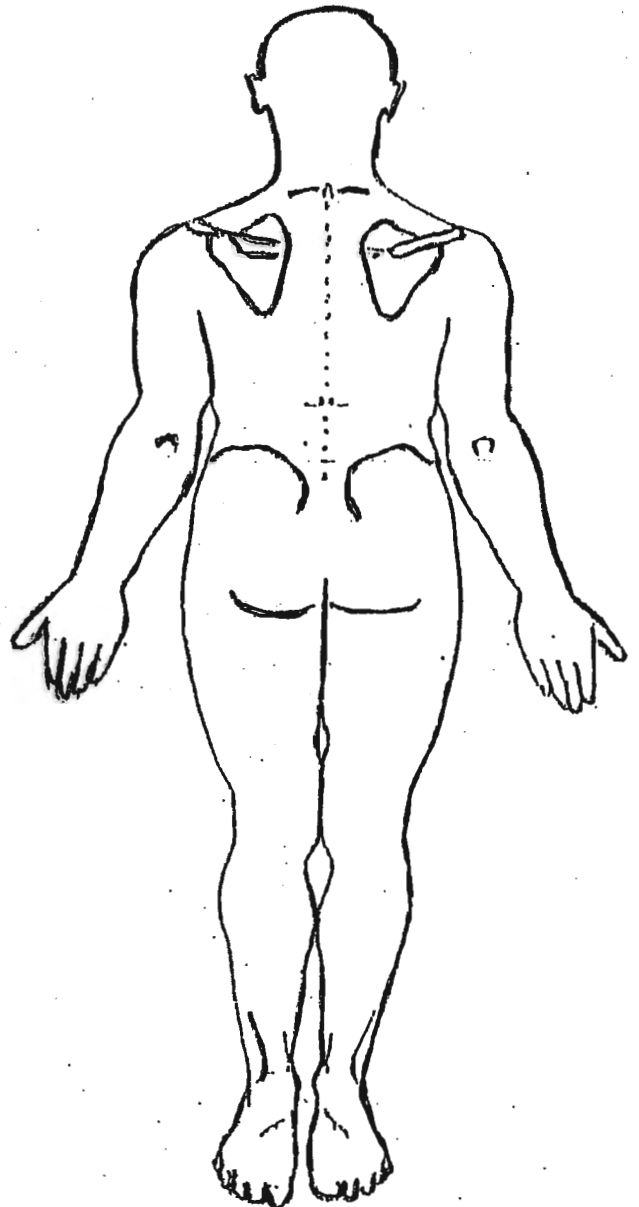
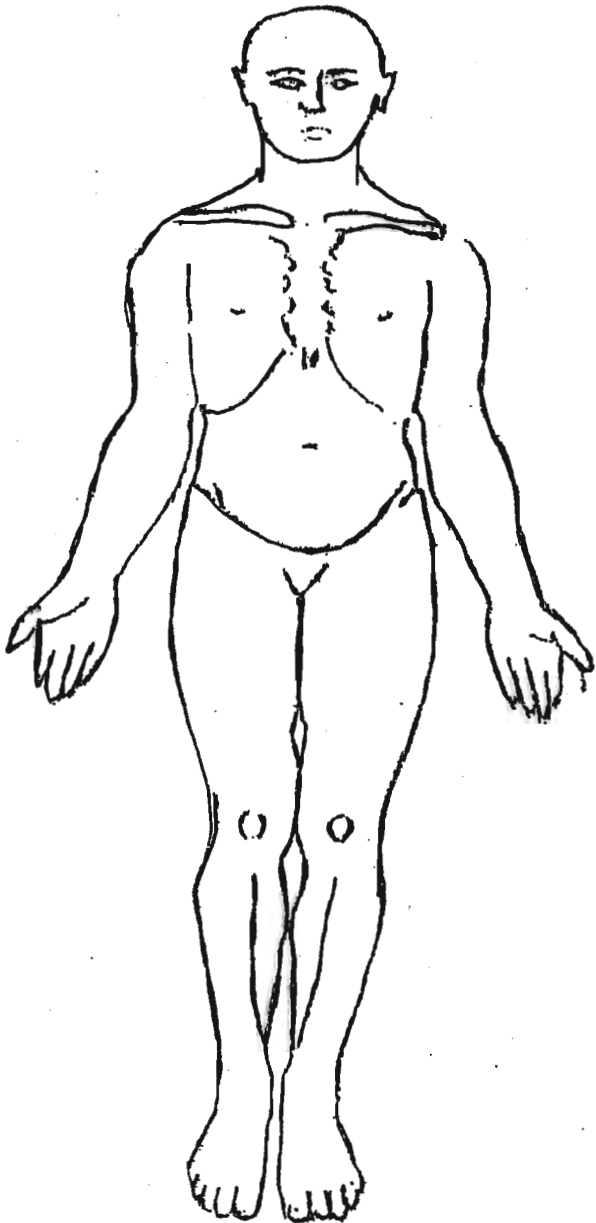
Tingling = T

Dull Pain = D

Sharp pain = P

Burning = B

Stiffness = S



CHIROPRACTIC CARE CASE HISTORY

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE (HOME): _____ (MOBILE): _____ E-MAIL: _____

SOCIAL SECURITY: _____ DRIVER LIC#: _____

AGE: _____ BIRTH DATE: _____ SEX: ___ MARITAL STATUS: M S W D NUMBER OF CHILDREN: _____

HEIGHT: _____ WEIGHT: _____ REFERRED BY: _____

OCCUPATION: _____ EMPLOYER: _____ YEARS EMPLOYED: _____

EMPLOYERS ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ EMPLOYER'S PHONE: _____ EXT: _____

SPOUSES NAME: _____ OCCUPATION EMPLOYER: _____

WHAT IS YOUR MAJOR COMPLAINT? _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

HAVE YOU HAS THIS OR A SIMILAR CONDITION IN THE PAST? _____

WHAT AGGRAVATES YOUR CONDITION? _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES NO CONSTANT COMES AND GOES

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? _____

LIST SURGICAL OPERATIONS: _____

ARE YOU TAKING ANY MEDICATIONS? _____ WHAT KIND? _____

OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS

DOCTOR'S NAME: _____ DIAGNOSIS: _____

X-RAYS OR OTHER TAKEN? _____ WHEN: _____ RESULTS: _____

PHYSIOTHERAPY: _____ LENGTH OF TIME UNDER CARE: _____ WERE YOU OFF WORK? _____

IF SO, HOW LONG: _____

INSURANCE INFORMATION

ARE YOU COVERED BY MEDICARE? YES NO MEDICARE #: _____ STATE INSURANCE AID? YES NO

DO YOU HAVE ANY GROUP, UNION OR PERSONAL HEALTH AND ACCIDENT INSURANCE? YES NO

NAME OF INSURANCE COMPANY: _____ POLICY #: _____ GROUP #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ AGENT: _____ CLAIM #: _____

I clearly understand and agree that all of the services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I ALSO AGREE TO PAY AND COLLECTION FEES ASSOCIATED WITH MY BILL INCURRED AT THIS OFFICE.

Patient's Signature: _____ Date: _____

SYMPTOM SURVEY

NAME _____

DATE _____

<p>1. GENERAL SYMPTOMS: (Circle as many as apply) A) Nervousness B) Irritability C) Fatigue D) Depression E) Loss of Sleep F) Tension G) PMS H) Jaw Pain</p>	<p>7. MIDBACK: (Circle as many as apply) A) Pain 1) Left 2) Right 3) Both Pain Level 1) Mild 2) Moderate 3) Severe Pain Type 1) Sharp/Stabbing 2) Dull Ache B) Muscle Spasm 1) Left 2) Right 3) Both</p>
<p>2. HEAD: (Circle as many as apply) A) Headache 1) Mild 2) Moderate 3) Severe How often: (1 2 3 4 5 6 7) Per (Day/Wk/ Mo) Are they: 1) Sharp 2) Dull Are they: 1) Constant 2) Intermittent Where Located: 1) Back of Head 2) Forehead 3) Temple 4) Right Side 5) Left Side 6) Behind Eyes B) Light Headed C) Memory Loss D) Fainting E) Blurred Vision F) Double Vision G) Sensitivity to Light H) Loss of Balance I) Hearing Loss J) Ringing in Ears</p>	<p>8. CHEST: (Circle as many as apply) A) Deep Chest Pain 1) Left 2) Right 3) Both Pain Level 1) Mild 2) Moderate 3) Severe B) Pain Around Ribs 1) Left 2) Right 3) Both C) Shortness of Breath D) Irregular Heartbeat</p>
<p>3. NECK: (Circle as many as apply) A) Pain 1) Left Side 2) Right Side 3) Both Pain Level 1) Mild 2) Moderate 3) Severe Pain Increased by: 1) Forward Movement 2) Backward Movement 3) Rotate Head Rt 4) Rotate Head Lt 5) Bend Neck Rt 6) Bend Neck Lt B) Stiffness C) Muscle Spasm D) Grinding/Grating Sounds</p>	<p>9. ABDOMINAL SYMPTOMS: (Circle as many as apply) A) Pain 1) Mild 2) Moderate 3) Severe B) Nervous Stomach C) Heartburn D) Gas E) Constipation F) Diarrhea G) Nausea H) Indigestion I) Loss of Appetite</p>
<p>4. SHOULDERS: (Circle as many as apply) A) Pain in Joint 1) Left 2) Right 3) Both B) Pain Across Shoulder 1) Left 2) Right 3) Both C) Limitation of Movement 1) Left 2) Right 3) Both D) Tension 1) Left 2) Right 3) Both</p>	<p>10. LOWBACK: (Circle as many as apply) A) Upper Lumbar Pain 1) Left 2) Right 3) Both B) Lower Lumbar Pain 1) Left 2) Right 3) Both C) Sacroiliac Pain 1) Left 2) Right 3) Both D) Muscle Spasm 1) Left 2) Right 3) Both Low Back Pain Level 1) Mild 2) Moderate 3) Severe</p>
<p>5. ARMS: (Circle as many as apply) A) Pain in Upper Arm 1) Left 2) Right 3) Both B) Pain In Elbow 1) Left 2) Right 3) Both C) Pain in Forearm 1) Left 2) Right 3) Both D) Pins & Needles (Arm) 1) Left 2) Right 3) Both E) Pins & Needles (Forearm) 1) Left 2) Right 3) Both F) Numbness in Arm 1) Left 2) Right 3) Both G) Numbness in Forearm 1) Left 2) Right 3) Both</p>	<p>11. HIPS AND LEGS: (Circle as many as apply) A) Pain in Buttocks 1) Left 2) Right 3) Both Pain Level 1) Mild 2) Moderate 3) Severe B) Pain in Hip Joint 1) Left 2) Right 3) Both Pain Level 1) Mild 2) Moderate 3) Severe C) Pain Down Leg 1) Left 2) Right 3) Both Location 1) Front 2) Back 3) Side Pain Radiates to 1) Knee 2) Calf 3) Foot D) Numbness Down Leg 1) Left 2) Right 3) Both Location 1) Front 2) Back 3) Side E) Pins & Needles (Legs) 1) Left 2) Right 3) Both Location 1) Front 2) Back 3) Side F) Knee Pain Leg 1) Left 2) Right 3) Both G) Leg Cramps 1) Left 2) Right 3) Both</p>
<p>6. HANDS: (Circle as many as apply) A) Pain in Wrist 1) Left 2) Right 3) Both B) Pain in Hand 1) Left 2) Right 3) Both C) Pins & Needles (Hand) 1) Left 2) Right 3) Both D) Numbness (Hand) 1) Left 2) Right 3) Both</p>	<p>12. FEET: (Circle as many as apply) A) Ankle Pain 1) Left 2) Right 3) Both B) Swollen Ankle 1) Left 2) Right 3) Both C) Foot Pain 1) Left 2) Right 3) Both D) Numbness of Feet 1) Left 2) Right 3) Both E) Swollen Feet 1) Left 2) Right 3) Both F) Cramps 1) Left 2) Right 3) Both</p>

Carlsbad Chiropractic
2808 Roosevelt Street, Suite 102
Carlsbad, Ca. 92008

Date of accident _____

Insurance information

Your Vehicle insurance
Company _____

Address of your ins.
Company _____

Policy Number _____

Phone Number (_____) _____

Adjuster Name (person handling the claim) _____

Claim Number _____

Other Party involved

Other parties Vehicle insurance Company _____

Address of their ins. Company _____

Policy Number _____

Phone Number (_____) _____

Adjuster Name (person handling the claim) _____

Claim Number _____

Carlsbad Chiropractic
Dr. Desi Gamboa
2808 Roosevelt St. #102
Carlsbad, CA 92008
TEL: 760-720-2273 (CARE)
FAX: 760-730-9911

NOTICE OF DOCTOR'S LIEN

Patient's Name: _____

I do hereby authorize Carlsbad Chiropractic to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was injured on _____

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing for medical services rendered as a result of this accident, and to withhold such sums from any settlement or judgment as may be necessary to adequately protect said doctor. And I hereby further give a LIEN on my case to said doctor against any and all proceeds (including "medical payments") of my settlement or judgment which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney must honor this lien as inherent to the settlement and enforceable upon the case as if the subsequent attorney executed it. You will notify said doctor if a new attorney replaces you within 30 days of such substitution of counsel, and you will notify such subsequent attorney, IN WRITING, when the file is transferred, of the existence of this lien agreement.

I expressly authorize and direct my attorney to release information concerning my case, including settlement disbursement, to said medical facility, if for any reason the doctor's lien is not fully and timely satisfied. You are further instructed to return this lien to the doctor promptly, and to complete and return Status Request correspondence, as reasonably required by the doctor, within ten (10) days of your receipt of such Requests.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement or judgment by which I may eventually recover.

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance as presently due and payable, and may pursue collection, accordingly.

Patient's Name: _____

Dated: _____ Patient's Signature: _____

The undersigned attorney of record for the above-referenced patient does hereby agree to observe ALL of the foregoing terms, and agrees to withhold such sums from any settlement or judgment as may be necessary to adequately protect said doctor named above. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorneys' fees and costs.

Dated: _____ Attorney's Signature: _____

Please date, sign and return one copy to the doctor's office, also keep one copy for your records.