

Chiropractic Center of Los Angeles

Office Procedure & Patient Introduction

Welcome to our office!

We are proud of the quality chiropractic care we provide. We specialize in structural problems and nerve-related conditions. Your initial consultation with the Doctor is complimentary. That includes discussing your condition with the Doctor and the Doctor making a determination whether chiropractic can help you. If so, an examination will be performed to determine the nature and extent of your concern. The Doctor will notify you if you are a candidate for chiropractic care before proceeding with your exam. We do not accept all cases. If we do not sincerely believe that your condition will respond satisfactorily to chiropractic care, we will not accept your case; however, we may refer you to another provider who can help you. The fee for the physical examination is \$85. More detailed or specific tests may be needed in complex or chronic cases to further diagnose your problem.

PLEASE FILL OUT ALL INFORMATION – IT IS ESSENTIAL FOR OUR EVALUATION!

Mr. ___ Mrs. ___ Miss ___ Ms. ___ Dr. _____	Occupation _____
Full Name _____	Employer _____
Home Address _____	Address of Employer _____
City, St., Zip _____	City, St., Zip _____
Home Phone _____	Work Phone _____
Cell Phone/Carrier _____	Spouse's Name _____
E-Mail _____	Spouse's Occupation _____
Birth date _____	Spouse's Employer _____
SS# _____	Spouse's Work Phone _____
Driver's Lic. _____	Emergency contact _____
Marital Status _____	Emergency contact phone _____
# of Children _____	

How do you prefer for us to contact you? Please check the 2 best options below:

Home Phone Cell Work E-Mail Text (please fill in cell carrier section above)

Whom may we thank for referring you? _____
Major complaint & symptoms _____
Secondary Complaint _____
How would you classify your condition? Minor Involved Severe
Do you have Insurance? Yes No Name of Insurance Co. _____
Is your condition due to an auto accident? Yes No Date of Injury _____
Is your condition due to an accident at work? Yes No Date of Injury _____
Previous treatment for this condition: Where? _____
When? _____ Any X-Rays taken? Yes No

MY HEALTH GOALS INCLUDE: (circle all that apply)

1. Relief of symptoms
2. Nutritional guidance
3. Exercise instruction
4. Muscle rehab/Core-strengthening
5. Natural, holistic options for other health concerns

(OVER)