CASE HISTORY

Name ____ Date _________________
Address ___________________________ City ________________ State _____ Zip_________
Home Phone _____________________ Cell Phone _____________________
E-mail Address ____
SS # ______________________ Driver Lic. # _________________
Age ________ Birth Date ________ Sex ________ Status M S W D No. Children _____
Occupation _______________ Employer ____________________ Work Ph. ______________
Work Address ______________________ City ________________ State _____ Zip _______
Best Times to Reach Me: ____________ or ____________. I prefer to be reached at Home Work
Spouse's Name _______________ Occupation _______________ Employer ________________
Person Responsible for this account _____________________ Referred by ___________________
What is your Major Complaint?____
Other Complaints ____
How Long have you had this condition ______ Have you had this or similar condition in the past? Yes No
What activities aggravate your condition? ____
Is condition getting progressively worse? Yes No Constant Comes and Goes
Is condition interfering with your: Work Sleep Daily Routine Exercise Hobbies
How long has it been since you felt really good? ____________________________________
List surgical operations: ____
____
Prescription Drug(s): ____
Non-Prescription Drug(s) / Supplements: ____
OTHER DOCTORS SEEN FOR THIS CONDITION : DC MD DDS DO
Doctor's Name __________________________________ Diagnosis ____________________
X-Rays and Lab Studies: ____
Treatment Rendered: ____
Results: ____ Time under care ______________
Were you off work? _____ If so, how long _____ Have you returned to the same job? If not, why ________

PLEASE PROVIDE COMMERICAL INSURANCE CARD(S) TO FRONT DESK FOR COPYING

INSURANCE INFORMATION (PERSONAL INJURY or WORKERS COMPENSATION)

Your Car/Work Comp Ins.Co. ________________Claim# ________Adjustor ______________
Billing Address ____ Ph. _______________
Do you have Med Pay as part of your car insurance policy? Yes No Dollar Amount? _________
At Fault Insurance Co. __________________ Claim# _____________Adjustor ______________
Billing Address ____Ph. _______________
Are you covered by Medicare? Yes No Medicare # ________________
Do you have a Medicare supplemental policy? Yes No Company Name __________________
Address _____________________ Policy #_________________ HMO? Yes No
Is your condition due to: Accident Illness Other ___________________________

ACCIDENT INFORMATION

Did your accident occur while at work? Yes No Were you involved in an automobile accident? Yes No
Date _______ Time _______ Injury reported to Supervisor Yes No Name __________________
Description of accident ____
____
Were you injured? _____ How? ____
Location ____
Were you unconscious? _____ Fractures _______ Cuts _______ Abrasions _______ Bruises _______
Patient taken to ___________________________ Hospital for ____________________________
Confined to hospital for _____ Days _____ Hours. Name of hospital doctor _______________
Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None
Describe ____

Patient's Signature ____ **Date** ______________

AUTO ACCIDENT INFO:

What was your position in the vehicle?
Driver Front Passenger Rear Passenger Pedestrian (not in car)

What type of vehicle were you driving?

Compact Car	Mid Size Car	Full Size Car	Compact Truck
Full Truck	Mini Van	Full Size Van	Sport Utility
Motorcycle	Motor Home	Bicycle	Lg. Sport Util.

What was your vehicle doing just prior to the accident?
Stopped at a light Slowing down to a stop
At a complete stop Increasing speed
Merging into traffic Changing lanes

Traveling at an approximate speed of:
5 mph 10 mph 15 mph 20 mph 25 mph 30 mph
35 mph 40 mph 45 mph 50 mph 55 mph 60 mph
65 mph 70 mph 75 mph 80 mph > 80 mph (Faster than 80 mph)

Who hit Who?
You were struck by another car You struck another car
You struck a stationary object

What was your vehicles point of impact?
Front Rear Right Side Left Side
Right Front Left Front Right Rear Left Rear

What was the other vehicle doing just prior to the accident?
Stopped at a stop lightSlowing down to a stop
At a complete stop Increasing speed
Merging into traffic Changing lanes

Traveling at an approximate speed of:
5 mph 10 mph 15 mph 20 mph 25 mph 30 mph
35 mph 40 mph 45 mph 50 mph 55 mph 60 mph
65 mph 70 mph 75 mph 80 mph > 80 mph (Faster than 80 mph)

What was the other vehicles point of impact?
Front Rear Right Side Left Side
Right Front Left Front Right Rear Left Rear

Were you wearing a seat restraint?
Full lap and shoulder restraint Lap restraint only
Shoulder restraint only I was not wearing a restraint

What position was your vehicles head rests in?
Lowest position Middle position
Highest position No head rest in vehicle

Did your vehicles air bags deploy?
Yes No

Were you prepared for the impact?
Came as complete surprise Aware and braced for collision
Aware but not braced for collision

What position was your head and neck in prior to impact?
Straight forward Tilted forward Rotated to left
Rotated to right Turned around Toward rear view mirror

What happened to your body at the moment of impact?
Body was tense for impact Body whipped forward/backward
Body torqued and twisted Body was thrown over seat
Body was thrown from vehicle Body was pinned in vehicle
Body was thrown from side to side Body was cut and bruised

What was your mental/emotional state immediately following?
Unconscious Shaken up
Disoriented Shaken up & Disoriented

Did you receive medical attention the scene of the accident?
Yes No

Where did you go immediately following the accident?
This Office Home Hospital
Personal Doctor Resume daily activities

What part of your body struck the below listed parts of your vehicle?

List Body Part(s) ____
Dashboard Windshield Steering Wheel Right Door
Left Door Seat Frame Unknown Object

WORK COMP INJURY

IF YOUR INJURY INVOLVED LIFTING, complete this section:

From where were you lifting an object?
Ground level A surface below ground level
A surface 1 to 3 feet high A surface 3 to 5 feet high
A surface above 5 feet high

How many pounds was the object you were lifting?
1 to 5 lbs. 5 to 10 lbs. 10 to 20 lbs.
20 to 40 lbs. 40 to 60 lbs. Over 60 lbs.

What position were you in while lifting the object?
Back was upright and straight Bent over at the waist
Twisted to the left side Twisted to the right side

What type of pain did you feel immediately after the injury?
Gripping pain Sharp pain Dull pain
Aches Popping feeling Paralysis

IF INJURY INVOLVED FALLING, complete this section:
From where did you fall at work?
Onto the ground while walking Onto the ground while running
From 1 to 3 feet high From 3 to 5 feet high
From 5 to 8 feet high From higher than 8 feet

What part of your body did you land on?

Head	Neck	Right Shoulder	Left Shoulder
Right Arm	Left Arm	Right Hand	Left Hand
Back	Right Buttock	Left Buttock	Tail Bone
Right Hip	Left Hip	Right Leg	Left Leg
Right Knee	Left Knee	Right Foot	Left Foot

What other areas of your body were affected by the fall?

Head	Neck	Right Shoulder	Left Shoulder
Right Arm	Left Arm	Right Hand	Left Hand
Back	Right Buttock	Left Buttock	Tail Bone
Right Hip	Left Hip	Right Leg	Left Leg
Right Knee	Left Knee	Right Foot	Left Foot

OTHER WORK RELATED INJURES
Raised up from bending over Twisted at the waist
Wrist injury from repetitive use Wrist injury from pulling
(Please describe all injuries in your own words on page 1 of this form)

JOB ANALYSIS INFORMATION

What regular activities did you perform at work?
Sitting Standing Walking
Running Driving Lifting
Bend/Stoop Squatting Crawling
Climbing Couching Reach above Shoulders
Kneeling Pushing/Pulling Maintain awkward position

How much do you regularly lift at your job?
Little to none 1 to 10 lbs. 10 to 20 lbs. 20 to 40 lbs.
40 to 60 lbs. 60 to 80 lbs. 80 to 100 lbs. Over 100 lbs.

Do you regularly bend over while lifting? Yes No

Are your hands subject to any of the below repetitive movements?
Right Light grasping Right Firm grasping Typing
Left Light grasping Left Firm grasping Computer Mouse

How many hours do you regularly perform the below activities?
Sitting: 1-2hrs 2-4hrs 4-6 hrs 6-8hrs
Standing: 1-2hrs 2-4hrs 4-6 hrs 6-8hrs
Walking: 1-2hrs 2-4hrs 4-6 hrs 6-8hrs

Patient Symptoms

Name ____ Date ______________

GENERAL SYMPTOMS: (Circle all that Apply)

Nervousness	Irritability	Fatigue
Depression	Loss of Sleep	Tension
PMS	Jaw Pain	Pain
Nervous stomach	Nausea	Gas
Constipation	Diarrhea	Heartburn
IndigestionLoss of Appetite		Foot/Ankle

Radiating Pain: Right Left Both

No Pain … Extreme Pain

Pain Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

HEAD: (Mark all that Apply)

Headaches: ☐ Sharp ☐ Dull ☐ Migraine

Location:	Back of Head Temples Right Side	Forehead Behind Eyes Left Side
Light Headed	Memory Loss	Fainting
Blurred Vision	Double Vision	Sensitive to Light
Balance Loss	Hearing Loss	Ringing in Ears

Radiating Pain: Right Left Both

No Pain … Extreme Pain

Pain Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

NECK: (Mark all that Apply)

	Left	Right	Both
Pain:	☐	☐	☐
Stiffness:	☐	☐	☐
Spasm:	☐	☐	☐
Grinding:	☐	☐	☐
Radiating Pain:	☐	☐	☐

Pain Increased By:

Forward Mvmnt	☐
Backward Mvmnt	☐
Rotate Head Left	☐
Rotate Head Right	☐
Bend Neck Left	☐
Bend Neck Right	☐

No Pain … Extreme Pain

Pain Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

SHOULDER: (Mark all that Apply)

	Left	Right	Both
Pain in Joint:	☐	☐	☐
Pain across the shoulder:	☐	☐	☐
Limitation of movement:	☐	☐	☐
Tension:	☐	☐	☐
Radiating Pain:	☐	☐	☐

No Pain … Extreme Pain

Pain Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

CHEST: (Mark all that Apply)

	Left	Right	Both
Pain Around Ribs:	☐	☐	☐
Deep Chest Pain:	☐	☐	☐
Shortness of Breath:	☐	☐	☐
Irregular Heartbeat:	☐	☐	☐
Radiating Pain:	☐	☐	☐

No Pain … Extreme Pain

Pain Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

MIDBACK: (Mark all that Apply)

	Left	Right	Both
Pain:	☐	☐	☐
Muscle Spasms:	☐	☐	☐
Radiating Pain:	☐	☐	☐

No Pain … Extreme Pain

Pain Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

ARM / HAND: (Mark all that Apply)

	Left	Right	Both
Pain in Upper Arm:	☐	☐	☐
Pain in Forearm	☐	☐	☐
Pain in Wrist	☐	☐	☐
Pain in Hand	☐	☐	☐
Numbness or Tingling in Upper Arm	☐	☐	☐
Numbness or Tingling in Forearm	☐	☐	☐
Numbness or Tingling in Wrist	☐	☐	☐
Numbness or Tingling in Hand	☐	☐	☐

No Pain … Extreme Pain

Pain Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

LOWBACK: (Mark all that Apply)

	Left	Right	Both
Upper Lumbar Pain:	☐	☐	☐
Lower Lumbar Pain:	☐	☐	☐
Sacro-iliac Pain	☐	☐	☐
Muscle Spasms:	☐	☐	☐
Radiating Pain:	☐	☐	☐

No Pain … Extreme Pain

Pain Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

HIP & LEGS: (Mark all that Apply)

	Left	Right	Both
Pain in Buttocks:	☐	☐	☐
Pain in Hip Joint:	☐	☐	☐
Knee Pain:	☐	☐	☐
Leg Cramps:	☐	☐	☐
Pain, Numbness, Tingling Down:	☐	☐	☐

No Pain … Extreme Pain

Pain Level: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Frequency: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Patient Signature ______________________________

Mark all of the below functions that you are unable to perform or are having difficulty performing due to each of the conditions indicated

ACTIVITIES OF DAILY LIVING

	General Symptoms	Head	Neck	Shoulder	Arm	Hand	Mid Back	Low Back	Hip/ Leg	Foot/ Ankle	Chest	Abdo minal
PERSONAL CARE												
Eating	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eliminating	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
COMMUNICATION												
Speaking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Writing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Keyboard	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ACTIVITY												
Sleeping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Running	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Working	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heavy Lifting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medium Lifting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Light Lifting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having Sex	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Exercising	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Working around house	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Working on hobbies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
SENSORY												
Hearing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seeing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Feeling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tasting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Smelling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
TRAVEL												
In a Car	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
In a Boat	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
In an Airplane	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
In a Train	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
SOCIAL												
Group Activities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emotional Stability	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including but not limited to, recommended food supplements, physiotherapy, rehabilitation, movement therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic or professionals named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working for or associated with, or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the office personnel the nature and purpose of the chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Complete Agreement

I understand that this Agreement constitutes the complete agreement and understanding between Patient and Office and will not be changed or modified in any way unless agreed to by both parties in writing. I have read, or have had read to me, the above consent. I have had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures and policies. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

PLEASE READ THIS DOCUMENT CAREFULLY!! PLEASE DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ IT COMPLETELY.

THE PATIENT HAS FULLY READ THIS AGREEMENT AND UNDERSTANDS AND AGREES TO ABIDE BY ALL OF ITS TERMS.

To be completed by patient

____
Print patient's Name

____
Signature of Patient

____
Date Signed

To be completed by patient's representative, if necessary, e.g., if the patient is a minor or is Physically or mentally incapable:

____
Print Name of Patient

____
Print Name of Patient's Representative

____
Signature of Patient's Representative

As: ______________________________
Relationship or Authority of patient's Representatvie

____
Date Signed

To be completed by doctor or staff

Name and address of clinic

CHIRO KINETICS CHIROPRACTIC CENTER
1399 YGNACIO VALLEY ROAD SUITE 31
WALNUT CREEK, CA 94598

Treating doctor(s) and personnel:

SCOTT L. BERGMAN, D.C.
RACHAEL BERGMAN

____
Witness to patient's Signature — Date

____
Translated by: — Date

<u>CHIRO KINETICS CHIROPRACTIC FINANCIAL POLICY</u>

DIRECT PAY/CASH BASED PATIENTS

The following policy applies to all patients defined as receiving treatment on a Direct Pay/Cash based plan. Chiro Kinetics defines a Direct Pay/Cash based payment plan as any patient other than a Workers Compensation patient or a Personal Injury patient.

Cash Payment Policies

1. The patient, or the person who is financially responsible for the patient, hereinafter referred to as "patient", agrees to provide all information necessary to enforce this plan, and understands that any non-compliance with this plan can and will result in collection activities, up to and including negative credit bureau reporting, and/or legal action.

2. Chiro Kinetics does not extend credit. Payment is due and is to be paid at the time service is rendered. The patient agrees to have a valid credit card number on file with Chiro Kinetics at all times, and authorizes Chiro Kinetics to use the credit card number for payment if the amount owing is not paid in full at the time of the visit to our office. The patient agrees to provide their Social Security number as well. Chiro Kinetics will hold this information in the strictest confidence and will only utilize the information for payment, and/or collection activities in the event that payment in full is not made at the time that services are rendered. If there is an occasion where the patient forgets to bring payment to the office when services are rendered, Chiro Kinetics will extend a five-day grace period for the payment to be made. If Chiro Kinetics does not receive the payment within the grace period, the credit card number on file will be used to pay the full outstanding amount due. If payment has not been received within 7 days, Chiro Kinetics will begin assessing a monthly late fee charge at the rate of 1.5% of the balance due. Any returned payments will be assessed a $35 service fee (will increase as bank charges increase), which will be added to the outstanding balance of the account. A minimum of twenty-four hour notice is required for rescheduling and/or cancellation of any appointment in the office or full fee for that service will be charged.

3. If you wish to make pre-payment arrangements for services provided to the patient please speak to the Doctor. Pre-payment can save you money and time spent in the office. Until a pre-payment agreement is reached and Chiro Kinetics receives the pre-payment amount, the patient is still responsible for payment in full at the time the service is rendered in our office up to the effective date of the pre-payment agreement. The agreement becomes effective when Chiro Kinetics receives the balance due for the pre-payment agreement.

Chiro Kinetics No Show Appointment Policy:

Canceling or rescheduling of any appointments requires twenty-four (24) hour notice to avoid a cancellation fee up to the full price of your scheduled office visits.

By signing this agreement, you agree that you have read and understood the above.

________________________________	________________________________
Signature of the financially responsible person	Date
Print name of the financially responsible person	Social Security number of the financially responsible person

Dr. Bergman and the staff at Chiro Kinetics work very hard to respect our patients' time by not double or triple booking appointments and making this a "no wait" office. In exchange for that courtesy, we have all our patients leave a credit card number on file to reserve their appointment times.

________________________________	________________________________
Visa, MasterCard, Am. Express, Discover number of Financially responsible person	Patient Name (if different than financially responsible person)

____________________ ____________
Expiration Date V-Code

________________________________	________________________________
Witness	Date