PATIENT INFORMATION

Patient #____________________ (Office use only) Date____________________

First Name____________________ M.I. _____ Last Name__________________________________Birthdate_______________ Age______ Sex M / F

Home Address____ City______________________________ State_____Zip_____________

Phone #: Home( )____________________ Work ( )____________________ Cell ( )____________________ Email______________________________

Preferred Method of contact (Please circle one of the above) NOTE: All Patient info is strictly confidential and guarded by HIPAA guidelines!

Social Security # ________-______-________ Driver's License # _________________________ Maritial Status (S M W D)

Occupation____ Employer ____

Work Address____City ______________________________ Zip____________________

Spouse's Name ____________________________________Number of Children _________ How were you referred? ______________________________

What is your major complaint?____ Date Condition began _______________

Is this condition due to an: A) Auto Accident* B) Work Injury* C) Unknown Cause D) Illness E) Other ______________________________

Is your condition: A) Improving B) Getting Worse C) About the Same D) Come and Go

Please rate your current pain level: 0 (None) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please rate your worst pain level: 0 (None) 1 2 3 4 5 6 7 8 9 10 (Severe)

Which activities aggravate your condition? A) Standing B) Walking C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing

Have you ever had these symptoms before? (Y / N) If so, when?____

Have you ever been to a chiropractor before? (Y / N) If so, when? ____

What is your goal for chiropractic treatment of your condition? A) Pain Relief Only B) Lasting Correction/Stabilization C) Maintenance/Wellness

Have you seen another doctor for this condition? A) M.D. B) Osteopath C) Acupuncturist D) Dentist E) Podiatrist E) Physical Therapist

Drs. Name____ Date Consulted__________________________ Diagnosis________________________

****If your condition is related to an auto accident or work injury, please stop at this point and notify the front desk****

GENERAL HEALTH QUESTIONS: Allergies____

Major Illnesses____Surgeries____

Hospitalizations____ Work/ Auto Injuries____

Medications____ Height______________ Weight___________ LMP(Females) _______________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I also authorize any medical records to be released to Dr. O'Toole and this office.

Patient's Signature____ Date____________________________________

Parent / Guardien (Only if minor)____

O'Toole Chiropractic, 23032 Alicia Parkway, Suite C, Mission Viejo, CA 92692 (949) 588-9550 Fax (949) 588-0568

(OVER→)

Symptoms Survey

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

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
Location: 1) Back of head 2) Forehead 3) Temples

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

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 Lt. 4) Rotate head Rt
5) Bend neck Lt. 6) Bend neck Rt.
B) Stiffness C) Muscle Spasms D) Grinding/Grating sounds

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) Limit of movement 1) Left 2) Right 3) Both

D) Tension 1) Left 2) Right 3) Both

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

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

7) Mid Back: (Circle as many as apply)
A) Pain location 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

8) Chest: (Circle as many as apply)

A) Deep Pain 1) Left 2) Right 3) Both
Pain level 1) Mild 2) Moderate 3) Severe
B) Pain in ribs 1) Left 2) Right 3) Both
C) Shortness of breath 1) Frequent 2)Intermittent
D) Irregular heartbeats 1) Frequent 2)Intermittent

9) Abdominal Symptoms:(Circle as many as apply)
A) Pain level 1) Mild 2) Moderate 3) Severe
B) Nervous Stomach C) Loss of appetite D) Gas

E) Constipation F) Diarrhea G) Heartburn

H) Indigestion I) Loss of Appetite

10) Lower Back (LB): (Circle as many as apply)
A) Upper LB Pain 1) Left 2) Right 3) Both
B) Lower LB Pain 1) Left 2) Right 3) Both
C) Sacro-Iliac Pain 1) Left 2) Right 3) Both
D) Muscle Spasms 1) Left 2) Right 3) Both
E) Pain level 1) Mild 2) Moderate 3)Severe

11) Hips & 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- Leg 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
F) Knee Pain 1) Left 2) Right 3) Both
G) Leg Cramps 1) Left 2) Right 3) Both

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) Numb Feet 1) Left 2) Right 3) Both
E) Swollen Feet 1) Left 2) Right 3) Both
F) Cramps 1) Left 2) Right 3) Both

O'TOOLE CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide O'Toole Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient's Name (Print)

____ ____________________
Patient's Signature Date

____ ____________________
Authorized Facility Signature Date

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of a rbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitrati on. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider , and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a pro per additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a be nefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _______. Effective as the date of first professional services.
If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT NAME:_________________________ PATIENT SIGNATURE **X**_________________________ DATE:______________
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**__________________________________ DATE:____

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor(s) of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and 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 risks and 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.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE **X**__________________________ Date: ____________________

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE