



Dr. Ken Best Chiropractor

144 S. Flores Street, Suite A, Los Angeles, CA 90048

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home or Cell: _____ Date of Birth: _____ Age: _____

Email address: _____

Sex: M or F Optional: pronouns he she they Weight _____ Height _____

Marital Status single, married, separated, divorced, widowed Spouse Name: _____

Referred by: _____ Emergency Contact: _____ Phone: _____

Main Complaint(s) - [Are you interested in just Pain Relief or Total Wellness ?]

Main complaint(s that brought you to this office? _____

When did the problem start? _____ Did it come on gradually? or suddenly?

Describe how the injury/problem occurred? _____

What makes it feel better? _____ What makes it feel worse? _____

Does the pain travel anywhere? If so where? _____

Do you have any numbness or tingling in your arms or legs? If so where? _____

How would you describe it? (sharp, dull, electric, etc) _____

How severe is it? (0 is no pain, 10 is unbearable pain) _____ Is it constant? or intermittent?

Is it worse in the A.M.? or P.M.? or all day? Has your sleep been affected? Yes No

It is getting better? or worse? or no change? Is it better with rest? Yes No

Have you had any trouble controlling bodily or daily functions? If so what? _____

Do you have any other symptoms that seem to be associated? If so what? _____

Has this condition caused you to avoid doing things that you enjoy doing? If so what? _____

List any doctors you have seen for this condition? _____

Have you ever had any Chiropractic care? Yes No. If so who? _____

Past Medical History

Do you have allergies? Yes No If yes, what? _____

Are you taking any medication/supplements for any reasons? Yes No If yes, please list: _____

Have you had any surgeries in the past? Yes No If yes, when was the surgery and what was it for?

Have you had any previous accidents? Yes No If yes, please describe the accident, any injuries, and any care received. _____

Family Health History

Associated health problems/deaths of immediate family (i.e. heart disease, cancer, stroke): please list relation to yourself and cause of death _____

Social and Occupational History:

Recreational activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

Review of Systems:

Do you have any problems with your: Eyes, Ears, Nose, Throat, Skin, Muscles, Digestive System, Vascular, Skeletal, or Urinary/Genital Systems? _____

Do you have any other illnesses or health problem that I need to be aware of: yes no

If yes, explain: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient/Guardian Signature

Date

Doctor's Signature

Date



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Welcome to Our Office!

Initial Visit:

On your first visit, a complete history will be taken and an examination performed as needed. Appropriate services will then be offered.

Financial Arrangements:

We accept as forms of payment: Cash, Venmo, Visa, MasterCard and American Express.

Payment is required at the time the treatment is rendered. A PROMPT PAY CASH DISCOUNT is already included in the listed prices and does not apply to patients with insurance.

Initial Intermediate Office Visit \$165 (55-60 min.)

Follow-Up Visits

- Minimal Office Visit \$85 (25-30 min.)
- Intermediate Office Visit \$125 (40-45 min.)
- Extended Office Visit \$165 (55-60 min.)

Treatment fees are subject to additional procedures. Cash or credit payments are required for all nutritional supplements received.

Appointments:

Please be on time for your appointment. Tardiness may have an effect on the length of your treatment time. **24 hours notice is required to cancel or change an appointment. Missed appointments or late cancellations will be subject to a full visit charge.**

Insurance:

You may receive a free 'walkout' receipt to submit for insurance reimbursement and you must prefillout your walkout slip with your main complaints for each visit and progress.

Personal Injury:

If you get injured in a car accident, notify the office. Personal injury cases require a more complex physical exam and treatments that are billed accordingly. We recommend adding a **'MedPay'** of at least \$5000 to your existing insurance policy if you do not have it.

I have read, understand and agree to the policy of this office and agree to pay for services rendered and for any missed appointments or for cancellation with less than 24 hours notice.

Print Name

Signature

Date