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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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, laser and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I will discuss with the doctor of chiropractic, Kenneth Best, D.C., and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that specific results are not guaranteed. I understand that during the initial phases of healing and treatment I may feel some discomfort or pain as my body returns to a balanced state.

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. Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness, disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you may have, including osteoporosis, heart disease, cancer, stroke, fracture or previous severe injury. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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.

*** DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS! ***

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By consenting to treatment, I have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interests to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____ _____ _____ _____

Print Name | Date | Signature | Date

Witness 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	$180	(55-60 min.)
Follow-Up Visits		
● Minimal Office Visit	$90	(25-30 min.)
● Intermediate Office Visit	$135	(40-45 min.)
● Extended Office Visit	$180	(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