Welcome to our office

Youdeem Chiropractic, Inc.
Dr. Gilbert Youdeem, D.C.,CCSP
9919 Walker St.
Cypress, CA 90630
(714) 527-7463

1 Please tell us about you!

Today's Date: ___/___/___ Driver's License #: _____ ☐ Male ☐ Female

Name: _____ What do you prefer to be called? _____

Birthdate: ___/___/___ Age: _____ SSN: ___-___-___

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: (___)_____ Cell phone: (___)_____ Other: (___)_____

Email address: _____ Whom can we thank for referring you? _____

Employer: _____ How long? _____

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

Occupation: _____ Work phone: (___)_____ Ext: _____

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Seperated* ☐ *Widowed* Spouse's name: _____

2 Reason for your visit?

Have you been treated by a Chiropractor before? ☐ Yes ☐ No Date of last visit: _____

Reason for treatment: _____

_____

How long were you treated? _____ Type of treatment given: _____

The reason for this visit is the result of (please circle): work, sports, auto(describe accident below), trauma or chronic.

Explain what happened: _____

_____

_____

_____

Please describe your pain and its location: _____

_____

When did the condition begin? ___/___/___ Is this condition getting worse? ☐ *Yes* ☐ *No* ☐ *Constant* ☐ *Comes and goes*

Is this condition interferring with your (please circle): Work, sleep, or daily routine?

If so, please explain: _____

_____

Have you had this or similiar condition in the past? ☐ Yes ☐ No Explain: _____

_____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If yes, where and by whom? _____

_____

Type of treatment given: _____

3 In event of an emergency

Who should we contact? _____ Relationship: _____

Homephone: (___)_____ Workphone: (___)_____ Cell: (___)_____

Who is your Medical Doctor? _____ Phone: (___)_____

May we contact him/her regarding your condition? ☐ Yes ☐ No

4 Health History

Are you taking any medications?

	Medication Name:	*Dose:*	*Reason:*	*Prescribed By:*
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				

Have you ever had any of the following disease/medical conditions? Please circle Y for yes or N for no

[Y N] Heart attack/stroke	[Y N] Fainting	[Y N] Emphysema	[Y N] Venereal Disease
[Y N] Congenital Heart Defect	[Y N] Asthma	[Y N] Psychiatric Problems	[Y N] Shingles
[Y N] Heart Murmur	[Y N] Lower Back Pain	[Y N] Kidney Problems	[Y N] Anemia
[Y N] Hepititis	[Y N] Heart Surg/Pacemaker	[Y N] Seizures/Epilipsy	[Y N] Rheumatic Fever
[Y N] Cancer / tumor	[Y N] Alcohol/Drug Abuse	[Y N] Diabetes	[Y N] Ulcers
[Y N] Frequent Neck Pain	[Y N] HIV / Aids	[Y N] Artificial Bones/Joints	[Y N] Corticosteroid Use
[Y N] Severe Frequent Headaches	[Y N] Difficulty Breathing	[Y N] Spinal Surgery	

Please list any other serious medical condition(s) you have ever had (including surgeries):

	Condition:	*Date:*	*Treatment Received:*	*Treated By:*
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				

Please list any previous accidents, falls or sports injuries you have ever had:

	Condition:	*Date:*	*Treatment Received:*	*Treated By:*
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				

Please list family health history such as Cancer/Diabetes/High blood pressure/Heart disease/Rheumatoid Arthritis:

_____

_____

_____

Do you smoke? ☐ Yes ☐ No If Yes, how much? _____ How long? _____

Do you drink alcohol? ☐ Yes ☐ No If Yes, how often? _____

For women: Are you taking Birth Control Pills? ☐ Yes ☐ No

Are you, or is there a chance you are pregnant? ☐ Yes ☐ No How long? _____

5 Account

Person ultimately responsible for account: _____ Relationship: _____

Billing Address: _____

SSN: ___ - ___ - ____

Driver's License #: _____

Workphone: (___) _____

Cell: (___) _____

Payment Method: ☐ Cash ☐ Check ☐ Credit

Card #: _____

☐ MC ☐ Visa Exp. Date: _____ 3 Dig # : _____

Please sign here if you would like us to charge your credit card for deductable, co-pay / co-insurance for all visits.

_____

Signature

6 Auto Related Accident

Date and time of Accident: _____ a.m. p.m. (please circle)

Were you the: ☐ Driver ☐ Front passenger ☐ Rear passenger

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle: _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing your seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest?

☐ *Above* ☐ *Below* ☐ *At base of skull*

What did your vehicle impact? ☐ Another vehicle ☐ Other If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No If yes, please describe: _____

Make and model of the vehicle you were occupying? _____

Name of the location/street on which you were traveling? _____

In which direction were you headed? ☐ *North* ☐ *South* ☐ *East* ☐ *West*

What was the approx. speed of your vehicle? _____ ☐ I was stopped

Did the impact to your vehicle come from the: ☐ *Front* ☐ *Rear* ☐ *Right side* ☐ *Left side* ☐ *Other*

During the impact, were you facing: ☐ *Right* ☐ *Left* ☐ *Forward*

Were you: ☐ Aware or ☐ Surprised by the impact?

If accident vehicle made impact with another vehicle, make & model of that other _____

Direction other vehicle was headed? ☐ *North* ☐ *South* ☐ *East* ☐ *West*

Speed of other vehicle? _____

7 Work Related Accident

Date and time of Accident: _____ a.m. p.m. (please circle)

Was your accident directly related to your work? [Y N]

Briefly describe the events that occurred just before and after your accident: _____

Give the address where the accident occurred: _____

Was anyone else present during the accident? [Y N]

Did you report the accident to your employer? [Y N]

What recommendations did your employer make just after your accident? _____

Has this type of accident happened to you before? [Y N]

To the best of your knowledge, has this accident occurred in your workplace before? [Y N]

In general:

Is your job physically stressful? [Y N]

Is your job mentally stressful? [Y N]

Is your workplace noisy? [Y N]

Have you changed jobs in the last year? [Y N]

8 After injury

Did the accident render you unconscious? ☐ Yes ☐ No If Yes, how long? _____

Please describe how you felt immediately after the accident: _____

_____

Have you gone to a hospital or seen another doctor? ☐ Yes ☐ No

When did you go? ☐ Just after the accident ☐ The next day ☐ 2days plus

How did you go? ☐ Ambulance or ☐ Private transportation

Name of hospital and/or attending doctor: _____ Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.

Describe any treatment you received: _____

_____

Were X-rays taken? [Y N] By whom? _____

Was medication prescribed? [Y N] Have you been able to work since this injury? [Y N]

Are your work activities restricted as a result of this injury? [Y N]

Indicate the symptoms that are a result of this accident:

☐ Memory Loss	☐ Back pain	☐ Jaw problems	☐ Nausea	☐ Irritability
☐ Headaches	☐ Back stiffness	☐ Arm/shoulder pain	☐ Stomach upset	☐ Fatigue
☐ Buzzing in ear	☐ Neck pain	☐ Chest pain	☐ Leg pain	☐ Difficulty sleeping
☐ Ears ringing	☐ Neck stiff	☐ Shortness of breath	☐ Numb feet/toes	☐ Dizziness

Other: _____

Is your condition getting worse? [Y N] ☐ Constant ☐ Comes and goes

Indicate your degree of comfort while performing the following

Please Circle Comfortable = C Uncomfortable = U Even if only sometimes painful = P

Laying on back.....C.....U.....P	Walking.....C.....U.....P	Bending.....C.....U.....P
Laying on side.....C.....U.....P	Running.....C.....U.....P	Kneeling.....C.....U.....P
Laying on stomach.... C.....U.....P	Sports.....C.....U.....P	Pulling.....C.....U.....P
Sitting.....C.....U.....P	Working.....C.....U.....P	Pushing.....C.....U.....P
Standing.....C.....U.....P	Lifting.....C.....U.....P	Reaching..... C.....U.....P
Stretching.....C.....U.....P		

Have you retained an attorney? ☐ Yes ☐ No

If yes, please give name & phone #: _____

9 Please read completely:

I here by authorize assignment of my insurance right and benefits directly to Dr. Gilbert Youdeem, D.C. for services rendered.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I authorize Dr. Gilbert Youdeem, D.C. and his staff to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, attorney or other health care professional involved in the case.

In the event other responsible parties fail to pay in full for services rendered, I understand I am ultimately and fully responsible for my account. I also understand that I am responsible for my deductible and co-payments at each office visit. *initial:* _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office 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. I also understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. *initial:* _____

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

initial: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health or insurance status.

Signature: _____ Please print your name: _____ Today's Date: ___/___/___