Welcome to our office

Youdeem Chiropractic, Inc.
Dr. Gilbert Youdeem, D.C., CCSP
9922 Walker St, Suite G
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: _____

Children? No ☐ Yes ☐ How many? _____

2 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 ☐

3 Account

Person ultimately responsible for account: ☐ Self ☐ Other (If other, Please compelete below)

What form of payment would you prefer? cash ☐ check ☐ credit card ☐

Name _____ Relationship: _____

Billing Address: _____

_____

Driver's License #: _____ SSN: ___-___-___

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

4 Previous Chiropractic care

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

Reason for last treatment: _____

_____

_____

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

5 Reason for your visit?

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

6 More about your visit? (If Accident Related Skip To Section) 7

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: _____

7 Auto related accident (If Not Accident Related Skip To Section) 9

Date and time of Accident: _____ a.m. p.m. (please circle)
Were you the: Driver ☐ Front passenger ☐ Rear passenger ☐ Number of people in accident vehicle: _____
If a traffic violation was issued, to whom was it issued? _____

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 Suprised 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? _____

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.S. ☐

Describe any treatment you received: _____

Were X-rays taken? [Y N] On what body part was X-ray taken? _____

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:

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

Have you retained an attorney? Yes ☐ No ☐

If yes, please give name & phone #: _____

9 Health history

Are you taking any medications?

	Medication Name:	*Dose:*	*Reason:*	*Prescribed By:*
N/A ☐				
N/A ☐				
N/A ☐				
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] Heart Murmur
[Y N] Congenital Heart Defect	[Y N] Asthma	[Y N] Psychiatric Problems	[Y N] Venereal Disease
[Y N] Hepitits	[Y N] Lower Back Pain	[Y N] Kidney Problems	[Y N] Shingles
[Y N] Cancer / tumor	[Y N] Heart Surg/Pacemaker	[Y N] Seizures/Epilipsy	[Y N] Anemia
[Y N] Frequent Neck Pain	[Y N] Alcohol/Drug Abuse	[Y N] Diabetes	[Y N] Rheumatic Fever
[Y N] Severe Frequent Headaches	[Y N] HIV / Aids	[Y N] Artificial Bones/Joints	[Y N] Ulcers
[Y N] High Blood Pressure	[Y N] Difficulty Breathing	[Y N] Spinal Surgery	[Y N] Corticosteroid Use

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☐				

9 Health history continued

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?_____

10 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 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 agree to 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: / /

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/Scrape to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing

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HIPAA PRIVACY REGULATIONS

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that Youdeem Chiropractic, Inc. (Dr. Gilbert Youdeem, D.C., CCSP) will not reveal to anybody personal information about you or your family member (i.e. name, address, social security number as well as other health information) without your permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation, or fund raising.

It is, however, understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, billing (paper and wire), include fax transmissions, insurance company follow-up and interaction with billing services relating to patient care
- Hospital workers, nurses, aids, and medical records department
- Emergency officials, Paramedics, fire personnel, emergency room physicians, nurses or technicians. Personal religious designate.
- Our office staff
- Pharmacists, drug program personnel/workers
- Completions of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

My signature below authorizes the release of any necessary information listed above.

Patient's Name _____ Signature of Patient/Guardian _____ Date _____