

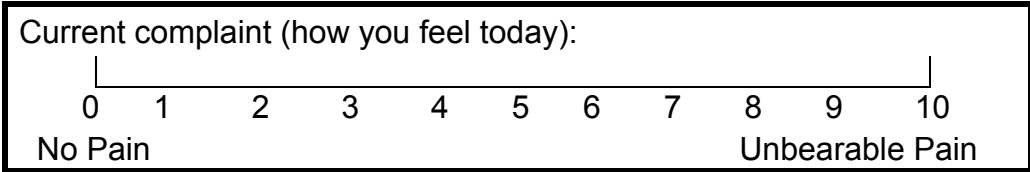
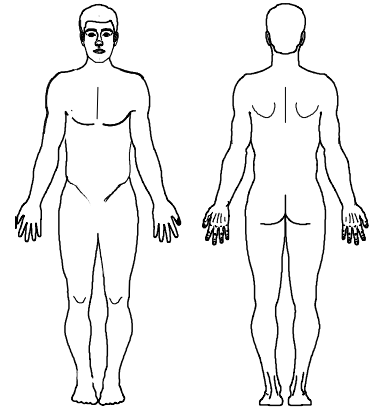
Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M / F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver Lic. #: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Health Plan: \_\_\_\_\_  
 Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Spouse Name: \_\_\_\_\_  
 Spouse Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Your Present Weight: \_\_\_\_\_

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

\_\_\_\_\_  
 \_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

**DATE PROBLEM BEGAN:** \_\_\_\_\_



How often are your symptoms present?  0 – 25%  26 – 50%  51 – 75%  76 – 100%

Can you perform your daily activities?  Yes  No (Describe) \_\_\_\_\_

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN?**  No  Yes Date(s) taken: \_\_\_\_\_

**WHAT AREAS WERE TAKEN?** \_\_\_\_\_

Please check all of the following that apply to you:  None Apply

- | No                       | Yes                      | Condition                   | No                       | Yes                      | Condition   |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use          | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances   |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____         | <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks  | <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           | <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                |                          |                          | _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                |                          |                          | _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma               |                          |                          |   |

Family History:  Cancer  Diabetes  High Blood Pressure  Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## HEALTH QUESTIONNAIRE

Name of Primary Care Doctor (M.D. or D.O.) \_\_\_\_\_

Phone \_\_\_\_\_ City \_\_\_\_\_

If you have had any of the following within the last 5 years,  
give an approximate date and the result:

Lab work (Cholesterol, Diabetes, etc...) \_\_\_\_\_

Diagnostic studies (MRI, Bone scan, Nerve conduction, etc...) \_\_\_\_\_

Scopes (Colonoscopy, Sigmoidoscopy, etc...) \_\_\_\_\_

Do you take any supplements (Vitamin, Minerals, Glucosamine, etc...)? [ ]Yes [ ]No  
if so, which ones?

Do you have any foot, arch or heel pain? [ ]Yes [ ]No

Do you have any other extremity pain (knee, wrist, elbow, etc...)? [ ]Yes [ ]No

If "Yes", explain:

Do have any recurring numbness or tingling? [ ]Yes [ ]No

Do you have vertigo or Meniere's? [ ]Yes [ ]No

Would you like to ask any specific questions before the exam begins? (list them here)

May we contact your primary care doctor regarding your healthcare and/or request  
your pertinent records? [ ]Yes [ ]No

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dr. Donald G. Ajlouni, D.C.  
Blossom Hill Chiropractic Offices  
4986 Cherry Avenue  
San Jose, CA 95118

**A. Treatment Consent**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above 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 have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other 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 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

\*\*\*\*\*

**B. Consent to Treat a Minor- IF PATIENT IS NOT A MINOR, SKIP TO SECTION C.**

The information I have given to this office pertaining to \_\_\_\_\_  
(Minor)

is truthful and complete to the best of my knowledge. I authorize the doctors and staff of Blossom Hill Chiropractic to administer such procedures and treatment as described above as they deem necessary to my (son), (daughter), (ward in my legal custody) The doctors have no implied guarantee of cure.

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Minor Child \_\_\_\_\_

Witnessed By \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

**C. Assignment of Benefits**

I, the undersigned, do hereby authorize payment directly to the office above, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office above as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_