INITIAL HEALTH STATUS

Email Address _____

Patient Name _____ Birthdate _____ Sex M / F

Address _____ City _____

State _____ Zip _____ Telephone (____) _____ Patient Primary Language _____

Occupation _____ Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

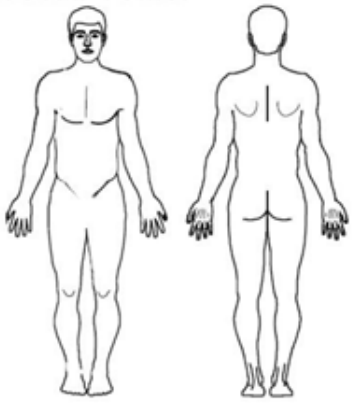
Subscriber Name _____ Health Plan: _____

Subscriber ID # _____ Group # _____ Spouse Name _____

Spouse Employer _____ City _____ State _____ Zip _____

Primary Care Physician Name _____ PCP Phone _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain

☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken: _____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) _____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) _____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) _____
_____
_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
_____
_____
☐ Medications _____
_____
_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, 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. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature _____ **Date** _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the answer which most closely describes your condition right now.**

1. **Pain Intensity**	No pain (0)	Mild pain (1)	Moderate pain (2)	Severe pain (3)	Worst possible pain (4)
2. **Sleeping**	Perfect sleep (0)	Mildly disturbed sleep (1)	Moderately disturbed sleep (2)	Greatly disturbed sleep (3)	Totally disturbed sleep (4)
3. **Personal Care (washing, dressing etc.)**	No pain no restrictions (0)	Mild pain no restrictions (1)	Moderate pain need to go slowly (2)	Moderate pain need some assistance (3)	Severe pain need 100% assistance (4)
4. **Travel (driving, etc.)**	No pain on long trips (0)	Mild pain on long trips (1)	Moderate pain on long trips (2)	Moderate pain on short trips (3)	Severe pain on short trips (4)
5. **Work**	Can do usual work plus unlimited extra work (0)	Can do usual work no extra work (1)	Can do 50% of usual work (2)	Can do 25% of usual work (3)	Cannot work (4)
6. **Recreation**	Can do all activities (0)	Can do most activities (1)	Can do some activities (2)	Can do few activities (3)	Cannot do any activities (4)
7. **Frequency of pain**	No pain (0)	Occasional pain 25% of day (1)	Intermittent pain 50% of the day (2)	Frequent pain 75% of the day (3)	Constant pain 100% of the day (4)
8. **Lifting**	No pain with heavy weight (0)	Increased pain with heavy weight (1)	Increased pain with moderate weight (2)	Increased pain with light weight (3)	Increased pain with any weight (4)
9. **Walking**	No pain any distance (0)	Increased pain after 1 mile (1)	Increased pain after ½ mile (2)	Increased pain after ¼ mile (3)	Increased pain any distance (4)
10. **Standing**	No pain after several hours (0)	Increased pain after several hours (1)	Increased pain after 1 hour (2)	Increased pain after ½ hour (3)	Increased pain with any standing (4)

Name: _____ _____ Total Score _____

PRINTED Date

DR. STEVEN M. GILLIS

CHIROPRACTOR

8281 Melrose Avenue, Suite #201, Los Angeles, CA 90046 Ph: (323) 655-8348 Fax: (323) 655-2959

WEBSITE: MyLAChiro.com

E-Mail: DrGillis@MyLaChiro.com

FINANCIAL AGREEMENT

Insurance companies will quote your Chiropractic benefits but **will not guarantee** payment until your claim is reviewed. As a courtesy, we will help you verify your benefits, submit your claim and provide any necessary documentation needed to support the claim.

You are responsible for any deductibles, co-payments or denied services by your insurance company. **Services that are not covered by insurance are Graston, Laser and Massage.**

Since we are contracted with many insurance companies, we will accept the contracted rate for services provided.
However, we are not required to accept insurance company contracted rates in the event your treatment is related to a personal injury claim. Upon us being informed of a personal injury claim a lien will be issued for unpaid monies.

If we are unable to verify your insurance benefits prior to your appointment, an estimate of your co-insurance, co-pay and/or deductible will be calculated and is due at the time of service. When your claim is processed, we will reconcile your account. If you do not have Chiropractic insurance coverage, the following fee schedule will apply and is due when services are rendered.
$109 Initial Visit (including exam and treatment)
$69 Established patient limited visit (non complex)
Extended/complex visits, supports and supplements are not included in this fee.

We respect your time and will do our best to honor your scheduled appointment time. In order to maintain this unique courtesy, we must charge for missed appointments and late cancellations.

$30 for missed office visit or late cancellation (less than 3 hour notification).
$70 for missed or late cancellation of 1 Hour Massage Therapy appointment (less than 8 hour notification).

Note: The late fee is not covered by insurance. It is your responsibility.
Thank you for your courtesy and understanding of this agreement.

I have read the above financial agreement and agree to the terms above.

(Signature)_____ (Date)_____

Steven M.Gillis, D.C.
8281 Melrose Ave. #201
Los Angeles, CA. 90046

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date: