VALLEY WHOLISTIC

# Patient History (Confidential)

Date: _____

**PATIENT INFORMATION:**

Name: _____ Birthdate: _____
Parent(s) Name (if patient is a minor): _____
Tel: Home: _____ Work: _____ Cel: _____ Other: _____
Address: _____ City: _____ State: _____ Zip :_____
Email: _____ Other: _____
Sex: ❑ Male ❑ Female Marital Status: ❑ M ❑ S ❑ W ❑ D No. Children: _____
Occupation: _____ Referred By: _____
Social Security No: _____ Driver Lic.#: _____
Employer: _____ Work Phone: _____Yrs. employed: _____
Employer's address: _____ City: _____ State: _____ Zip: _____

**EMERGENCY CONTACT:**

Name: _____ Address: _____ City: _____ State: _____ Zip: _____
Phones: Day: _____ Eves: _____ Cell: _____ E-mail: _____
Relationship: _____ Occupation: _____

Main concern(s) you would like to address: _____
_____
_____
How long have you had this condition?_____ Have you had this or similar conditions in the past?_____
What activities aggravate your condition?_____
Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes ❑ Other _____
Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily routine ❑ Other _____
How long has it been since you really felt good? _____

Surgeries: _____
_____
_____
Accidents and/or significant trauma (including emotional): _____ _____
_____
_____
Illness(es): _____
_____
_____
Current Medications: _____
_____
_____
Any nonprescription drugs? ❑ Yes ❑ No What kind?_____

**OTHER DOCTOR SEEN FOR THIS CONDITION:** ❑ None ❑ MD ❑ DC ❑ DO ❑ DDS ❑ Other _____
Doctor's Name_____ Telephone: _____ Diagnosis: _____
Please check all tests you have had: ❑ X-rays ❑ Urinalysis ❑ Blood Test ❑ Other: _____
What treatments: ❑ Pills ❑ Shots ❑ Traction ❑ Physiotherapy ❑ Other _____
Length of time under his care:_____ Results: _____
Were you off work? ❑ Yes ❑ No For how long? _____ Have you returned to your same job? ❑ Yes ❑ No
If not, why? _____

I give my permission for chiropractic treatments and/or BodyTalk sessions to be rendered. I understand the nature of those treatments. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at the time of service.

**See the back page > > >**

Patient's Signature_____ Date_____

# IMPORTANT: Please check all of your present symptoms

**HEAD:**
- ❑ Headache
  - ❑ Sinus (allergy)
  - ❑ Entire head
  - ❑ Back of head
  - ❑ Forehead
  - ❑ Temples
  - ❑ Migraine
- ❑ Head feels heavy
- ❑ Loss of memory
- ❑ Light-headedness
- ❑ Fainting
- ❑ Light bothers eyes
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Loss of taste
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Loss of hearing
- ❑ Pain in ears
- ❑ Ringing in ears
- ❑ Buzzing in ears

**NECK:**
- ❑ Pain in the neck
- ❑ Neck pain with movement
  - ❑ Forward
  - ❑ Backward
  - ❑ Turn to left
  - ❑ Turn to right
  - ❑ Bend to left
  - ❑ Bend to right
- ❑ Pinched nerve
- ❑ Neck feels out of place
- ❑ Muscle spasms in neck
- ❑ Popping sounds in neck
- ❑ Arthritis in neck

**SHOULDERS:**
- ❑ Pain in shoulder joint (R-L)
- ❑ Pain across shoulders
- ❑ Bursitis (R-L)
- ❑ Throbbing pain at night
- ❑ Arthritis (R-L)
- ❑ Can't raise arm
  - ❑ Above shoulder level
  - ❑ Over head
- ❑ Tension in shoulders
- ❑ Pinched nerve in shoulders (R-L)
- ❑ Muscle spasms in shoulders

**ARMS & HANDS:**
- ❑ Pain in upper arm
- ❑ Pain in elbow
- ❑ Movement aggravated
- ❑ Tennis elboe
- ❑ Pain in forearm
- ❑ Pain in fingers
- ❑ Sensation of pins and needles in arms
- ❑ Sensation of pins and needles in fingers
- ❑ Numbness in arms
- ❑ Numbness in fingers
- ❑ Fingers go to sleep
- ❑ Hans cold
- ❑ Swollen joints in fingers
- ❑ Arthritis in fingers
- ❑ Loss of grip strength

**MID-BACK:**
- ❑ Mid-back pain
  - ❑ Location
- ❑ Pain between shoulder blades
- ❑ Sharp stabbing
- ❑ Dull ache
- ❑ Pain from front to back
- ❑ Muscles spasms
- ❑ Pain in kidney areas

**CHEST:**
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Pain around ribs
- ❑ Breast pain
- ❑ Dimples or orange peel breasts
- ❑ Irregular heartbeat

**ABDOMEN:**
- ❑ Nervous stomach
- ❑ Nausea
- ❑ Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Hemorrhopids
- ❑ Foods you cannot eat _____

_____
_____
_____
_____
_____
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_____

**LOW BACK:**
- ❑ Low back pain
- ❑ Upper lumbar
- ❑ Lower lumbar
- ❑ Sacroiliac
- ❑ Low back pain is worse when:
  - ❑ Working
  - ❑ Lifting
  - ❑ Stooping
  - ❑ Standing
  - ❑ Sitting
  - ❑ Bending
  - ❑ Coughing
  - ❑ Lying down (sleeping)
  - ❑ Walking
  - ❑ Slipped disk
  - ❑ Pain relieves when _____

    _____

    _____
- ❑ Low back feels out of place
- ❑ Muscles spasms
- ❑ Arthritis

**HIPS, LEGS, FEET:**
- ❑ Slipped diskPain in buttocks (R-L)
- ❑ Slipped diskPain in hip joint (R-L)
- ❑ Pain down leg (R-L)
- ❑ Pain down both legs
- ❑ Knee pain
  - ❑ Inside
  - ❑ Outside
- ❑ Leg cramps
- ❑ Cramps in feet (R-L)
- ❑ Pins & needles in legs (R-L)
- ❑ Numbness of toes
- ❑ Feet feel cold
- ❑ Swollen ankles (R-L)
- ❑ Swollen feet (R-L)

**WOMEN ONLY:**
- ❑ Menstrual pain _____ (where)
- ❑ Cramping
- ❑ Irregularity
- ❑ Cycle _____ days
- ❑ Birth control _____ (type)
- ❑ Hysterctomy
- ❑ Genital cancer _____
- ❑ Discharge
- ❑ Menopause started _____ (date)
- ❑ Tumors
- ❑ Abortions
- ❑ Are you, or do you think you might be pregnant?

**MEN ONLY:**
- ❑ Urinary frequency
- ❑ Difficulty in starting
- ❑ Night urination
- ❑ Prostate pain/swelling

**GENERAL:**
- ❑ Nervousness
- ❑ Irritable
- ❑ Depressed
- ❑ Fatigue
- ❑ Generally feel rundown
- ❑ Normal sleep _____
- ❑ Loss of sleep _____ hrs./night
- ❑ Loss of weight _____ Lbs.
- ❑ Gain weight _____ Lbs.
- ❑ Coffee _____ cups / day
- ❑ Tea _____ cups / day
- ❑ Cigarettes _____ pack(s) / day
- ❑ Diabetes
- ❑ Hypoglycemia
- ❑ Other _____

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**ALLERGIES/INTOLERANCES:**

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**REMARKS:**

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VALLEY
WHOLISTIC

# APPOINTMENT CANCELLATION FEE

We respect your schedule and make every effort to minimize the waiting time during your visits to our office. If you need to cancel or postpone an appointment, thank you for advising us 24 hours in advance.

A cancellation fee may be charged if you miss a scheduled appointment.

I acknowledge the above policy regarding appointment cancellations:

_____ _____

Signature of Patient or Guardian Date

Bernadette Rosenstiel, D.C. / 22030 Clarendon Street, Suite 101 / Woodland hills, California 91367

Telephone: 818-887-4000 / Fax: 818-887-7092 / mail@drRosenstiel.com

## VALLEY WHOLISTIC HEALTH CENTER

## NOTICE OF PRIVACY PRACTICES
## SIGNATURE SHEET

Valley Wholistic Health Center is required, by law, to maintain the privacy and confidentiality of our patients' protected health information and to provide you with notice of our legal duties & privacy practices with respect to your protected health information. It is your right to request and receive a copy of our NOTICE OF PRIVACY PRACTICES if you so desire.

### DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

I understand that my health care information may be used or disclosed outside the offices of Valley Wholistic Health Center for the purposes of Treatment, Payment, Worker's Compensation, Emergency, Public Health, Judicial & Administrative Proceedings, Law Enforcement, Organ Donation, Research, Public Safety, Specialized Government Use, Scheduling, Change of Address and/or in the event of untimely Decease.

### PATIENT INFORMATION RIGHTS

I understand that I have certain privacy and health information rights, including the right to inspection and accounting of, and the right to request restrictions or make alterations of my health care information rights.

### CHANGES TO THE NOTICE OF PRIVACY PRACTICES

I understand that Valley Wholistic Health Center reserves the right to amend their Notice of Privacy Practices.

### COMPLAINTS

I understand that complaints regarding my privacy and health information rights should be directed to Elizabeth Winter of Valley Wholistic Health Center.

**MY SIGNATURE SERVES AS PROOF THAT I HAVE READ, UNDERSTAND AND AGREE TO VALLEY WHOLISTIC HEALTH CENTER'S NOTICE OF PRIVACY PRACTICES.**

NAME _____

SIGNATURE _____ DATE _____