



PATIENT INTAKE FORM

WELCOME and THANK YOU for choosing our office. We are committed to helping you reach your health and wellness potential. At SLO Wellness Center we believe in whole person health. First through role modeling, and second through teaching, we are passionate about motivating our patients and the community to *Eat Well, Move Well, and Be Well.*

PATIENT DEMOGRAPHICS

First Name: _____ Last Name: _____ MI: _____ Preferred Language: _____

Male: _____ Female: _____ DOB: ____/____/____ Age: _____ SSN: ____/____/____ Marital Status: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Asian ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

Smoking Status: ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoker

Email: _____ Home Phone: _____ Cell Phone: _____ Cell Provider: _____

Preferred method of communication for patient reminders: ☐ Email ☐ Text ☐ Phone Call

Employer: _____ Occupation: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who can we thank for referring you in? _____ Relationship: _____

HEALTH AND WELLNESS

Please rate between 1-10 with "1" being the lowest where you feel like your health is in each of the categories below:

1.) EXERCISE: _____

Do you exercise? ☐ Yes ☐ No How often? ☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X per week Other: _____

What activities? ☐ Running ☐ Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming Other: _____

2.) DIET: _____

My diet consists of: ☐ Fruits ☐ Vegetables ☐ Chicken ☐ Beef ☐ Fish ☐ Fast Foods ☐ Soda

Do you drink alcohol? ☐ Yes ☐ No How much? _____ Do you drink coffee? ☐ Yes ☐ No How much? _____

3.) SLEEP: _____

4.) STRESS MANAGEMENT: _____

What other forms of health care do you use? ☐ Acupuncture ☐ Massage Other: _____

Are you currently taking any supplements (i.e. vitamins, supplements, herbs)?

Supplement Name	Dosage and Frequency

Please list your health and wellness related goals:

Physical Goals	Nutritional/ Biochemical Goals	Psychological Goals

PURPOSE OF VISIT

Reason for this visit (main complaint): _____

Is this a result of a work injury / auto accident? ☐Yes ☐No If so when: _____

When did this condition begin? ____/____/____ Did it begin: ☐Gradual ☐Sudden ☐Progressive over time

Is there anything that relieves your symptoms? _____ Have you experienced this before? ☐Yes ☐No

Is the problem interfering with your work, sleep, daily routine?: ☐Yes ☐No

If so, please describe: _____

Have you sought any other treatment before this?: ☐Yes ☐No

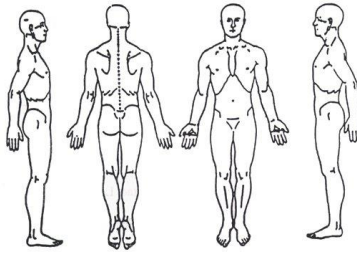
If so, please describe: _____

Who is your primary treating physician? (MD) _____

Have you ever seen a chiropractor before? ☐Yes ☐No If so whom: _____ Where: _____

Are you pregnant? ☐Yes ☐No Are you breast feeding? ☐Yes ☐No

Please show us where you are experiencing pain and/or discomfort by putting circling the body:



MEDICAL CONDITIONS

Are you currently taking any medications? (please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Family Medical History (Record one diagnosis in your family history and the affected)

Diagnosis: (write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		X		

Please list any other serious medical conditions you have or ever had:

Medical Condition	Surgeries	Serious Accident / Trauma
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

SYMPTOMS OF SPINAL MISALIGNMENT

Misalignments of the spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. PLACE A CHECK MARK IN THE APPROPRIATE BOX INDICATING YOUR PAST OR PRESENT SYMPTOMS.



CERVICAL	
C1	<input type="checkbox"/> headaches <input type="checkbox"/> nervousness <input type="checkbox"/> insomnia <input type="checkbox"/> colds <input type="checkbox"/> high blood pressure <input type="checkbox"/> anxiety <input type="checkbox"/> depression <input type="checkbox"/> seizures <input type="checkbox"/> chronic fatigue <input type="checkbox"/> memory <input type="checkbox"/> migraines <input type="checkbox"/> dizziness
C2	<input type="checkbox"/> sinus <input type="checkbox"/> allergies <input type="checkbox"/> double vision <input type="checkbox"/> ringing in ears <input type="checkbox"/> earache <input type="checkbox"/> crossed eyes <input type="checkbox"/> fainting spells <input type="checkbox"/> deafness
C3	<input type="checkbox"/> neuralgia <input type="checkbox"/> neuritis <input type="checkbox"/> acne or pimples <input type="checkbox"/> eczema
C4	<input type="checkbox"/> hay fever <input type="checkbox"/> adenoid infections <input type="checkbox"/> post nasal drip
C5	<input type="checkbox"/> laryngitis <input type="checkbox"/> hoarseness <input type="checkbox"/> throat conditions
C6	<input type="checkbox"/> stiff neck <input type="checkbox"/> tonsillitis <input type="checkbox"/> whooping cough <input type="checkbox"/> frozen shoulder <input type="checkbox"/> bursitis
C7	<input type="checkbox"/> bursitis <input type="checkbox"/> colds <input type="checkbox"/> thyroid conditions <input type="checkbox"/> goiter <input type="checkbox"/> tennis elbow <input type="checkbox"/> tendinitis
THORACIC	
T1	<input type="checkbox"/> asthma <input type="checkbox"/> cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> arm & hand pain <input type="checkbox"/> carpal tunnel
T2	<input type="checkbox"/> arrhythmia <input type="checkbox"/> heart murmurs <input type="checkbox"/> chest pain
T3	<input type="checkbox"/> bronchitis <input type="checkbox"/> pleurisy <input type="checkbox"/> pneumonia <input type="checkbox"/> congestion <input type="checkbox"/> influenza
T4	<input type="checkbox"/> gall stones <input type="checkbox"/> jaundice <input type="checkbox"/> shingles
T5	<input type="checkbox"/> fever <input type="checkbox"/> low blood pressure <input type="checkbox"/> anemia <input type="checkbox"/> poor circulation <input type="checkbox"/> arthritis
T6	<input type="checkbox"/> nervous stomach <input type="checkbox"/> ulcers <input type="checkbox"/> indigestion <input type="checkbox"/> heartburn
T7	<input type="checkbox"/> diabetes <input type="checkbox"/> ulcers <input type="checkbox"/> gastritis <input type="checkbox"/> hypoglycemia
T8	<input type="checkbox"/> lowered immune resistance <input type="checkbox"/> acute and chronic infection <input type="checkbox"/> hiccups
T9	<input type="checkbox"/> allergies <input type="checkbox"/> hives <input type="checkbox"/> hypertension <input type="checkbox"/> anemia <input type="checkbox"/> obesity <input type="checkbox"/> hair loss
T10	<input type="checkbox"/> hardening of arteries <input type="checkbox"/> chronic fatigue <input type="checkbox"/> nephritis
T11	<input type="checkbox"/> skin conditions <input type="checkbox"/> acne <input type="checkbox"/> eczema <input type="checkbox"/> pimples
T12	<input type="checkbox"/> rheumatism <input type="checkbox"/> bloating/gas <input type="checkbox"/> certain types of sterility
LUMBAR	
L1	<input type="checkbox"/> constipation <input type="checkbox"/> colitis <input type="checkbox"/> diarrhea <input type="checkbox"/> hernias
L2	<input type="checkbox"/> appendicitis <input type="checkbox"/> cramps <input type="checkbox"/> acidosis <input type="checkbox"/> varicose veins
L3	<input type="checkbox"/> painful/difficult/frequent urination <input type="checkbox"/> menstrual troubles <input type="checkbox"/> miscarriages <input type="checkbox"/> bed wetting <input type="checkbox"/> impotency <input type="checkbox"/> knee pain
L4	<input type="checkbox"/> sciatica <input type="checkbox"/> lumbalgia <input type="checkbox"/> difficult painful or too frequent urination <input type="checkbox"/> backaches
L5	<input type="checkbox"/> poor circulation in legs <input type="checkbox"/> swollen ankles <input type="checkbox"/> weak arches <input type="checkbox"/> leg cramps
SACRAL	
Sacrum	<input type="checkbox"/> sacroiliac conditions <input type="checkbox"/> spinal curvatures
Coccyx	<input type="checkbox"/> hemorrhoids <input type="checkbox"/> itching <input type="checkbox"/> pain at end of spine when sitting

FINANCIAL OPTIONS

SLO Wellness Center is a Patient Centered Practice. We provide care based on a patients desire to obtain optimum health. We also offer simple solutions for understanding and using your insurance benefits. Please follow the flow chart below to understand more about your specific insurance benefits.

INSURANCE

In Network Insurance

Blue Shield PPO
United Health Care
Multi Plan
Marian (dignity health)

Out of Network Insurance

*Blue Cross
Aetna
Cigna
Health Net
Medicare
All HMO Plans

As a courtesy we will bill your insurance for your treatment

Deductible: _____ Left: _____

Estimated copay/co-insurance: _____

Visits (Per Year): _____

Estimated Initial Visit: \$88 -\$125

Estimated Follow up Visit: \$52

Deductible: _____ Left: _____

Initial Visit: \$134 Follow up visits: \$59

*Blue Cross SISC, PG&E or Anthem plans managed
by ASHP allow 5 visits per year

*If your deductible is met, it will be your responsibility to
pay your copay or co-insurance at time of service **

*If your plan has out of network benefits, any
reimbursement for treatment will come directly to you**

NO INSURANCE

Initial Visit: \$134

Follow up Visit: \$59

Please inquire about our package rates or family plans and check with your doctor to see what would be the best option for your treatment plan.

Please note:

- There is a \$5.00 late fee for all unpaid bills over 30 days
- There is a \$25.00 fee for missed appointments and those not cancelled 24 hours in advance

Signature _____ Date _____

***In order to receive insurance benefits, the member must be covered at the time of service.**

The amounts above are only estimates; we will know the exact amount when we receive the explanation of benefits from your insurance. As quoted by your insurance company, this is not a guarantee of payment or coverage. This information does not pre-authorize payment. Benefits are subject to change. Other terms and limitations may apply even though such provisions are not indicated on your insurance company's web site. All claims are subject to medical review according to the information submitted by the provider of the service and are subject to benefit maximums and other terms of the member's contract. Please refer to the applicable benefit agreements to determine the appropriate payment amounts and any limitations or exclusions. If this is HMO coverage, benefits must be authorized by the member's assigned medical group.

Sandy Sachs, D.C. • Rex Stevens, D.C. • Molly Stevens, D.C. • Aram Casparian, D.C.
1428 Phillips Lane Suite 300 • San Luis Obispo • CA 93401 • 2231 Bayview Heights • Los Osos • CA 93402
P 805.543.8688 • F 805.543.8732 • www.slowellness.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with the opportunity to review a Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of SLO Wellness Center health care operations. The Notice of Privacy Practices also describes my rights, SLO Wellness Center duties with respect to my protected health information. The Notice of Privacy Practices is posted by the front desk.

SLO Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

SLO Wellness Center may need to use my name, address, phone number, and my clinical record to contact me with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to me. If this contact is made by phone and I am not at home, a message will be left on my answering machine. By signing this form, I am giving SLO Wellness Center authorization to contact me with these reminders and information.

Patient Name: _____ Patient Signature: _____ Date: _____

If patient is under 18 years of age

Legal Guardian Name: _____ Legal Guardian Signature: _____ Date: _____

CONSENT FOR BILLING AND TREATMENT

PLEASE READ CAREFULLY AND INITIAL EACH SECTION

SLO Wellness Center (SWC) is a partnership between Stevens Chiropractic Inc., Sachs Chiropractic Inc., and Casparian Chiropractic Inc. SWC invites you to discuss with us any questions regarding your care and our services.

☐ I understand that SWC can bill my insurance as a courtesy and that I am ultimately responsible for my payment of services provided.

☐ I authorize SWC and whomever they designate to administer treatment as they deem necessary.

☐ I authorize my provider(s) and/or managed care organization to release my information to provide other health care providers with information related to my care as well as to process insurance claims.

☐ I consent to the performance of chiropractic adjustments and other chiropractic procedures by SWC D.C.'s including: Dr. Molly Stevens, Dr. Rex Stevens, Dr. Sandy Sachs, and Dr. Aram Casparian

☐ I have read, or have had read to me, the above consent. By signing below I agree to chiropractic services and intend this consent form to cover the entire course of treatment for my present condition(s) and for any further condition(s) for which I seek treatment in this office.

Patient Name: _____ Patient Signature: _____ Date: _____

If patient is under 18 years of age

Legal Guardian Name: _____ Legal Guardian Signature: _____ Date: _____

For Office Use Only

Witness Name (office staff): _____ Witness Signature: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

PLEASE READ CAREFULLY AND SIGN BELOW

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: _____	Patient Signature: _____	Date: _____
<i>If patient is under 18 years of age</i>		
Legal Guardian Name: _____	Legal Guardian Signature: _____	Date: _____
Witness Name (office staff): _____	Witness Signature: _____	Date: _____

Sandy Sachs, D.C. • Rex Stevens, D.C. • Molly Stevens, D.C. • Aram Casparian, D.C.
1428 Phillips Lane Suite 300 • San Luis Obispo • CA 93401 • 2231 Bayview Heights • Los Osos • CA 93402
P 805.543.8688 • F 805.543.8732 • www.slowellness.com

SYMPTOMS OF SPINAL MISALIGNMENT

Misalignments of the spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. PLACE A CHECK MARK IN THE APPROPRIATE BOX INDICATING YOUR PAST OR PRESENT SYMPTOMS.



CERVICAL	
C1	<input type="checkbox"/> headaches <input type="checkbox"/> nervousness <input type="checkbox"/> insomnia <input type="checkbox"/> colds <input type="checkbox"/> high blood pressure <input type="checkbox"/> anxiety <input type="checkbox"/> depression <input type="checkbox"/> seizures <input type="checkbox"/> chronic fatigue <input type="checkbox"/> memory <input type="checkbox"/> migraines <input type="checkbox"/> dizziness
C2	<input type="checkbox"/> sinus <input type="checkbox"/> allergies <input type="checkbox"/> double vision <input type="checkbox"/> ringing in ears <input type="checkbox"/> earache <input type="checkbox"/> crossed eyes <input type="checkbox"/> fainting spells <input type="checkbox"/> deafness
C3	<input type="checkbox"/> neuralgia <input type="checkbox"/> neuritis <input type="checkbox"/> acne or pimples <input type="checkbox"/> eczema
C4	<input type="checkbox"/> hay fever <input type="checkbox"/> adenoid infections <input type="checkbox"/> post nasal drip
C5	<input type="checkbox"/> laryngitis <input type="checkbox"/> hoarseness <input type="checkbox"/> throat conditions
C6	<input type="checkbox"/> stiff neck <input type="checkbox"/> tonsillitis <input type="checkbox"/> whooping cough <input type="checkbox"/> frozen shoulder <input type="checkbox"/> bursitis
C7	<input type="checkbox"/> bursitis <input type="checkbox"/> colds <input type="checkbox"/> thyroid conditions <input type="checkbox"/> goiter <input type="checkbox"/> tennis elbow <input type="checkbox"/> tendinitis
THORACIC	
T1	<input type="checkbox"/> asthma <input type="checkbox"/> cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> arm & hand pain <input type="checkbox"/> carpal tunnel
T2	<input type="checkbox"/> arrhythmia <input type="checkbox"/> heart murmurs <input type="checkbox"/> chest pain
T3	<input type="checkbox"/> bronchitis <input type="checkbox"/> pleurisy <input type="checkbox"/> pneumonia <input type="checkbox"/> congestion <input type="checkbox"/> influenza
T4	<input type="checkbox"/> gall stones <input type="checkbox"/> jaundice <input type="checkbox"/> shingles
T5	<input type="checkbox"/> fever <input type="checkbox"/> low blood pressure <input type="checkbox"/> anemia <input type="checkbox"/> poor circulation <input type="checkbox"/> arthritis
T6	<input type="checkbox"/> nervous stomach <input type="checkbox"/> ulcers <input type="checkbox"/> indigestion <input type="checkbox"/> heartburn
T7	<input type="checkbox"/> diabetes <input type="checkbox"/> ulcers <input type="checkbox"/> gastritis <input type="checkbox"/> hypoglycemia
T8	<input type="checkbox"/> lowered immune resistance <input type="checkbox"/> acute and chronic infection <input type="checkbox"/> hiccups
T9	<input type="checkbox"/> allergies <input type="checkbox"/> hives <input type="checkbox"/> hypertension <input type="checkbox"/> anemia <input type="checkbox"/> obesity <input type="checkbox"/> hair loss
T10	<input type="checkbox"/> hardening of arteries <input type="checkbox"/> chronic fatigue <input type="checkbox"/> nephritis
T11	<input type="checkbox"/> skin conditions <input type="checkbox"/> acne <input type="checkbox"/> eczema <input type="checkbox"/> pimples
T12	<input type="checkbox"/> rheumatism <input type="checkbox"/> bloating/gas <input type="checkbox"/> certain types of sterility
LUMBAR	
L1	<input type="checkbox"/> constipation <input type="checkbox"/> colitis <input type="checkbox"/> diarrhea <input type="checkbox"/> hernias
L2	<input type="checkbox"/> appendicitis <input type="checkbox"/> cramps <input type="checkbox"/> acidosis <input type="checkbox"/> varicose veins
L3	<input type="checkbox"/> painful/difficult/frequent urination <input type="checkbox"/> menstrual troubles <input type="checkbox"/> miscarriages <input type="checkbox"/> bed wetting <input type="checkbox"/> impotency <input type="checkbox"/> knee pain
L4	<input type="checkbox"/> sciatica <input type="checkbox"/> lumbalgia <input type="checkbox"/> difficult painful or too frequent urination <input type="checkbox"/> backaches
L5	<input type="checkbox"/> poor circulation in legs <input type="checkbox"/> swollen ankles <input type="checkbox"/> weak arches <input type="checkbox"/> leg cramps
SACRAL	
Sacrum	<input type="checkbox"/> sacroiliac conditions <input type="checkbox"/> spinal curvatures
Coccyx	<input type="checkbox"/> hemorrhoids <input type="checkbox"/> itching <input type="checkbox"/> pain at end of spine when sitting