



PATIENT INFORMATION FORM

Today's Date ____/____/____

ABOUT YOU

Name: _____ What you prefer to be called: _____
Birthdate: ____/____/____ Age: _____ SS#: ____-____-____ Male ____ Female ____
Mailing Address: _____ City _____ Apt/Ste. _____ Zip _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-Mail: _____ Referred By: _____
Employer: _____ Occupation: _____
Marital Status: ____ Minor ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed
Spouse's Name: _____ Any children? ____ Y ____ N How Many? _____

REASON FOR VISIT

The reason for this visit is a result of: ____ Work ____ Sports ____ Auto ____ Trauma ____ Chronic

Explain what happened: _____

Please describe the pain & its location: _____

When did this condition begin? ____/____/____ Is it getting worse? ____ Y ____ N ____ Constant ____ Comes & Goes

Is this condition interfering with your : ____ Work ____ Sleep ____ Daily Routine

If so, please explain: _____

Have you had this or a similar condition in the past? ____ Y ____ N

If so, please explain: _____

Have you been treated by a medical physician for this condition? ____ Y ____ N

If so, where? _____

Have you ever been treated by a chiropractor before? ____ Y ____ N Were X-Rays taken? ____ Y ____ N

If so, whom? _____ Phone: _____

INSURANCE: If you have insurance that may cover chiropractic, please provide your current insurance card so that we may make a copy.

IN CASE OF EMERGENCY

Who should we contact? _____ Relation: _____

Home Phone: _____ Work Phone: _____

Who is your medical doctor? _____ Phone: _____

HEALTH HISTORY

Are you taking any of the following medications? ____ Pain medication (including aspirin) ____ Muscle relaxers
____ Blood thinners ____ Insulin ____ Anti-Inflammatories ____ Other(s) _____

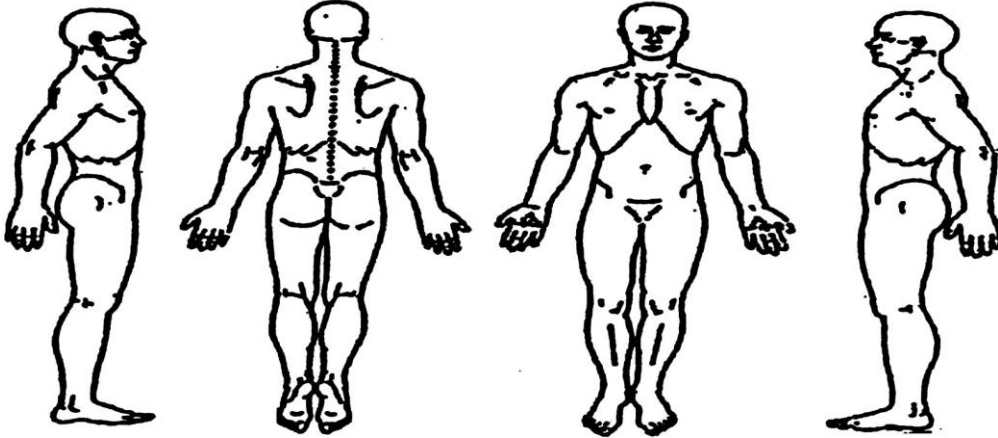
1. Is today's problem caused by: Auto Accident Workman's Compensation

Dr. Matthew H. Cobb (Chiropractor)

8950 W. Olympic Blvd., Suite 206, Beverly Hills, CA 90211 • Phone: (310) 786-9264 • Fax: (310) 786-9268
website: www.drcobbdc.com • email: innatebalancechiropractic@gmail.com



2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time) |
| <input type="checkbox"/> Frequently (51-75% of the time) | <input type="checkbox"/> Intermittently (1-25% of the time) |

4. How would you describe the type of pain?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: _____ |

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- | | | |
|--|---|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one |

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10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis

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- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other: _____

Females Only

- Hormonal Replacement
 Pregnancy
 Birth Control Pills

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes

if yes, why _____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

ACCOUNT INFORMATION

* I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

* 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 date of service and no other financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

* I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

* I understand 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 to the information I have provided.

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Patient Signature: _____ Date: ____/____/____

Consent to Exam and Treat

The undersigned consents to examination which may include physical, orthopedic, neurological, laboratory, and radiographic as needed to evaluate and or diagnose the patient. The undersigned also consents to therapeutic procedures as are deemed necessary by their doctor in the course of treatment. These therapeutic procedures may include any of the following: Spinal and extraspinal manipulation/adjustments, ice, heat, electrical muscle stimulation, ultrasound, laser/light therapy, soft tissue manipulation, taping, exercise, nutritional supplementation and any other procedures as prescribed by the doctor.

The staff of this office does everything within their power to minimize any risk involved in any procedure. In spite of that, there is a very small risk of complications. These complications can include, but not limited to, increased pain, swelling, bruising, clicking, sensory changes, bleeding, fracture, dizziness, weakness or stroke. Again, complications are exceedingly rare; however, it is necessary to inform you of their possibility.

I have read the above information and by my signature give my consent for evaluation, examination and treatment. I understand that I may question any procedure at any time. I also understand that I may decline any procedure I am not completely comfortable with.

Printed Name: _____ Signature: _____ Date: _____

Cancellation Policy

We aim to provide our patients the highest quality care. Because we do not double-book appointments, when you break your appointment, we are not able to fill the empty spot.

If you are unable to keep your appointment, please notify us as soon as possible. This allows us to offer this appointment slot to other patients who may have an immediate need to our care. Our answering machine is on 24 hours a day.

A \$25 service fee will be charged to you for missed appointments that are canceled the day of your appointment.

No call/no show or cancellation 2 hours prior to your appointment is \$75.

Patient Signature

Date