Chiropractic Center of Los Angeles

Office Procedure & Patient Introduction

Welcome to our office!

We are proud of the quality chiropractic care we provide. We specialize in structural problems and nerve-related conditions. Your initial consultation with the Doctor is complimentary. That includes discussing your condition with the Doctor and the Doctor making a determination whether chiropractic can help you. If so, an examination will be performed to determine the nature and extent of your concern. The Doctor will notify you if you are a candidate for chiropractic care before proceeding with your exam. We do not accept all cases. If we do not sincerely believe that your condition will respond satisfactorily to chiropractic care, we will not accept your case; however, we may refer you to another provider who can help you. The fee for the physical examination is $85. More detailed or specific tests may be needed in complex or chronic cases to further diagnose your problem.

PLEASE FILL OUT ALL INFORMATION – IT IS ESSENTIAL FOR OUR EVALUATION!

Mr. ____ Mrs. ____ Miss ____ Ms. ____ Dr. _____
Full Name _____
Home Address _____
City, St., Zip _____
Home Phone _____
Cell Phone/Carrier _____
E-Mail _____
Birth date _____
SS# _____
Driver's Lic. _____
Marital Status _____
# of Children _____

Occupation _____
Employer _____
Address of Employer _____
City, St., Zip _____
Work Phone _____
Spouse's Name _____
Spouse's Occupation _____
Spouse's Employer _____
Spouse's Work Phone _____
Emergency contact _____
Emergency contact phone _____

How do you prefer for us to contact you? Please check the 2 best options below:

___Home Phone ____Cell ____ Work ____E-Mail ____Text (please fill in cell carrier section above)

Whom may we thank for referring you? _____
Major complaint & symptoms _____
Secondary Complaint _____
How would you classify your condition? _____ Minor _____ Involved _____ Severe
Do you have Insurance? ____ Yes _____ No Name of Insurance Co. _____
Is your condition due to an auto accident? _____Yes _____No Date of Injury _____
Is your condition due to an accident at work? ____Yes _____No Date of Injury _____
Previous treatment for this condition: Where? _____
When? _____Any X-Rays taken? _____Yes _____No

MY HEALTH GOALS INCLUDE: (circle all that apply)

1. Relief of symptoms
2. Nutritional guidance
3. Exercise instruction
4. Muscle rehab/Core-strengthening
5. Natural, holistic options for other health concerns

(OVER)