GALE CHIROPRACTIC

VITAL INFORMATION

Date_____

Name _____ Social Security Number _____

Date of Birth _____ Age _____ Gender _____ Height _____ Weight _____

Address _____ City _____ State_____ Zip _____

Home Phone _____ Cell Phone _____ Business Phone_____

Email Address _____ Occupation _____

Marital Status: circle one: Single Married Divorced Widowed

Name of Spouse _____ Number of Children ___ Name(s) Age(s)_____

Whom may we thank for referring you to our office? _____

CHIROPRACTIC EXPERIENCE

Have you ever experienced Chiropractic? Circle one. Yes or No

Approximate date of last spinal checkup or adjustment? _____

Reason for those visits? _____

WHAT BRINGS YOU HERE?

If applicable, where is the **location** of your concern?_____

When did this health concern **begin**? _____

Describe the **quality** of the sensation:

Sharp Ache Throbbing Burning Tingling Numbness Stabbing Tight Other:_____

Is your concern is in a **single spot** or does it **radiate out?** Circle one.

How often are you **aware** of this sensation?

Constant (75%-100%) Frequent (51%-75%) Occasional (26%-50%) Intermittent (0-25%)

What makes it feel **better?** _____

What makes it feel **worse?** _____

Has this feeling been: getting better getting worse staying the same coming and going

Is this injury or illness **work-related?** _____ *If yes, have you reported this to your employer?* _____

Is this injury or illness related to an **automobile accident?** _____

Have you **stopped doing anything** since the onset?_____

Have you ever **had anything similar**? Explain _____

Have you attempted some other means of handling this concern? Heat/cold/vitamins/massage other_____

Have you **consulted any type of doctor** for this concern? ____Type of Care: _____Results?_____

GOALS FOR CARE

People choose to receive Chiropractic care for many different reasons. What best describes your choice?

☐ **Relief Care:** To relieve your symptoms.

☐ **Corrective Care:** Correcting, & stabilizing the cause(s) of the problem, as well as relieving the symptoms.

I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Signature **Date** **Guardian or Spouse's Signature Authorizing Care**

ABOUT YOUR HEALTH & LIFESTYLE

Circle those that apply.

Massage Vitamins Homeopathy Herbs Acupuncture Yoga Lift Weights Run Cleanse
Consume Organic Foods Probiotics Other_____

How many hours do you typically sleep? _____
Do you sleep on your side/back/ stomach? (Circle)
Do you drink water? _____ glasses / day
Do you drink alcohol? _____ Drinks / day
Do you smoke? no yes _____Cigs/ day
Do you grind or clench your teeth? no yes
How many hours do you sit daily? _____

Describe the quality of your sleep_____
Do you sleep with a cervical pillow? no yes
How many bowel movements each day? _____
Do you drink coffee or tea? ____Cups/day
Do you floss your teeth? no yes
Do you breathe consciously? no yes
Fitness level (1-100%)_____% Energy level_____%

Are you taking any drugs currently or have you been on any medication in the past?

Circle those that apply.

Pain Killers Muscle Relaxers Stimulants Tranquilizers Anti-depressants Anti-inflammatory
Blood Pressure Cholesterol Anti-anxiety Birth Control Diet Pills Thyroid
Other_____ Over the Counter _____
Recreational drugs (name them) _____

Major Surgeries/ Operations/ Hospitalizations:

1. _____ 2. _____
3. _____ 4. _____

Traumas & Accidents:

Please describe any accidents you have experienced from birth to present.

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered as these items provide Dr. Gale a window to your overall health status. Please circle if you've experienced any of the following:

Headache	Congenital Heart Defect	Asthma	Kidney Problems	Thyroid Problems	Neck Pain
Fever	High Blood Pressure	Chronic Cough	Frequent Urination	Anemia	Pain between the shoulders
Allergy	Low Blood Pressure	Frequent Colds	Painful Urination	Hepatitis A, B, or C	Low back Pain
Dizziness	Difficulty Breathing	Tuberculosis	Blood in Urine	Shingles	Tail Bone Pain
Low Energy		Pneumonia	Venereal Disease	Cancer	Numbness or Pain
Sinus Troubles	Varicose Veins		Prostate Problems	Chemotherapy	in Arms, Hands, Legs, or Feet
Sore Throat	Poor Circulation	Constipation	Inability to Control Urine		
Pain in Eyes	Pain Over Heart	Poor Digestion	Bed Wetting	HIV/ AIDS	
Deafness	Heart Attack	Nausea	Loss of Sleep	Diabetes	Poor Coordination
Ear noises	Stroke	Vomiting	Psoriasis	Ulcers/ Colitis	Inability to Concentrate
Heart Murmur	Flatulence	Eczema	Swollen Ankles	Diarrhea	Digestive Problems

For Women Only

Are you pregnant?	☐ no ☐ yes	Excessive flow?	☐ no ☐ yes	Breast Implants?	☐ no ☐ yes
Are you nursing	☐ no ☐ yes	Irregular cycles?	☐ no ☐ yes		
Are you taking birth control?	☐ no ☐ yes	Cramps?	☐ no ☐ yes		

What are your hobbies/sports/activites?_____

Anything else that you have attention on that when resolved will help you be healthier?_____

SYMPTOM SURVEY FORM

NAME _____ **DOCTOR** _____ **DATE** _____

Phone # ( ) _____

Birthdate: ___/ ___/ ___ Sex: M___ F___

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3
(1) for MILD symptoms
(2) for MODERATE symptoms
(3) for SEVERE symptoms
Leave the box BLANK if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up—fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep—hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression—"blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movements painful or difficult
82 ☐ Worrier, feels insecure
83 ☐ Feeling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attacks
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

GROUP 6

- 98 ☐ Loss of taste for meat
- 99 ☐ Lower bowel gas several hours after eating
- 100 ☐ Burning stomach sensations, eating relieves
- 101 ☐ Coated tongue
- 102 ☐ Pass large amounts of foul-smelling gas
- 103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 ☐ Mucus colitis or "irritable bowel"
- 105 ☐ Gas shortly after eating
- 106 ☐ Stomach "bloating" after eating

GROUP 7

(A)

- 107 ☐ Insomnia
- 108 ☐ Nervousness
- 109 ☐ Can't gain weight
- 110 ☐ Intolerance to heat
- 111 ☐ Highly emotional
- 112 ☐ Flush easily
- 113 ☐ Night sweats
- 114 ☐ Thin, moist skin
- 115 ☐ Inward trembling
- 116 ☐ Heart palpitates
- 117 ☐ Increased appetite without weight gain
- 118 ☐ Pulse fast at rest
- 119 ☐ Eyelids and face twitch
- 120 ☐ Irritable and restless
- 121 ☐ Can't work under pressure

(B)

- 122 ☐ Increase in weight
- 123 ☐ Decrease in appetite
- 124 ☐ Fatigue easily
- 125 ☐ Ringing in ears
- 126 ☐ Sleepy during day
- 127 ☐ Sensitive to cold
- 128 ☐ Dry or scaly skin
- 129 ☐ Constipation
- 130 ☐ Mental sluggishness
- 131 ☐ Hair coarse, falls out
- 132 ☐ Headaches upon arising wear off during day
- 133 ☐ Slow pulse, below 65
- 134 ☐ Frequency of urination
- 135 ☐ Impaired hearing
- 136 ☐ Reduced initiative

GROUP 7 (continued)

(C)

- 137 ☐ Failing memory
- 138 ☐ Low blood pressure
- 139 ☐ Increased sex drive
- 140 ☐ Headaches, "splitting or rending" type
- 141 ☐ Decreased sugar tolerance

(D)

- 142 ☐ Abnormal thirst
- 143 ☐ Bloating of abdomen
- 144 ☐ Weight gain around hips or waist
- 145 ☐ Sex drive reduced or lacking
- 146 ☐ Tendency to ulcers, colitis
- 147 ☐ Increased sugar tolerance
- 148 ☐ Women: menstrual disorders
- 149 ☐ Young girls: lack of menstrual function

(E)

- 150 ☐ Dizziness
- 151 ☐ Headaches
- 152 ☐ Hot flashes
- 153 ☐ Increased blood pressure
- 154 ☐ Hair growth on face or body (female)
- 155 ☐ Sugar in urine (not diabetes)
- 156 ☐ Masculine tendencies (female)

(F)

- 157 ☐ Weakness, dizziness
- 158 ☐ Chronic fatigue
- 159 ☐ Low blood pressure
- 160 ☐ Nails weak, ridged
- 161 ☐ Tendency to hives
- 162 ☐ Arthritic tendencies
- 163 ☐ Perspiration increase
- 164 ☐ Bowel disorders
- 165 ☐ Poor circulation
- 166 ☐ Swollen ankles
- 167 ☐ Crave salt
- 168 ☐ Brown spots or bronzing of skin
- 169 ☐ Allergies ~~+~~endency to asthma
- 170 ☐ Weakness after colds, influenza
- 171 ☐ Exhaustion—muscular and nervous
- 172 ☐ Respiratory disorders

FEMALE ONLY

- 173 ☐ Very easily fatigued
- 174 ☐ Premenstrual tension
- 175 ☐ Painful menses
- 176 ☐ Depressed feelings before menstruation
- 177 ☐ Menstruation excessive and prolonged
- 178 ☐ Painful breasts
- 179 ☐ Menstruate too frequently
- 180 ☐ Vaginal discharge
- 181 ☐ Hysterectomy/ovaries removed
- 182 ☐ Menopausal hot flashes
- 183 ☐ Menses scanty or missed
- 184 ☐ Acne, worse at menses
- 185 ☐ Depression of long standing

MALE ONLY

- 186 ☐ Prostate trouble
- 187 ☐ Urination difficult or dribbling
- 188 ☐ Night urination frequent
- 189 ☐ Depression
- 190 ☐ Pain on inside of legs or heels
- 191 ☐ Feeling of incomplete bowel evacuation
- 192 ☐ Lack of energy
- 193 ☐ Migrating aches and pains
- 194 ☐ Tire too easily
- 195 ☐ Avoids activity
- 196 ☐ Leg nervousness at night
- 197 ☐ Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Nutrition Survey

What sources of information have you used to gain information about nutrition and nutritional supplements?

_____

_____

Have you received information from multi-level marketing programs, health food store literature, TV/Radio shows etc? If yes, what did you learn?

_____

_____

_____

Have there been health products that you've purchased because they were "new"? If yes, what are/were they? _____

_____

How adequate do you consider your knowledge of nutrition / supplementation is in supporting your own health? (Place a mark, 0 lowest, 100 highest)

0 10 20 30 40 50 60 70 80 90 100

Please note approx. what % of your diet is a._____ and what % is b._____

a. Natural foods, as close to nature as possible.

b. Refined foods, high carbo/fat/sugar, fast foods, pizza, homogenized milk, etc.

Based on your knowledge of nutritional supplements, (circle as appropriate)

1. I'd rather not take vitamins due to dangerous side effects.
2. I'd rather not take supplements because I've had failures in the past.
3. I'd rather have high dosage supplements.
4. I'd rather have whatever is least expensive.
5. I'd rather have concentrated whole food supplements.
6. Somebody,_____has told me what to take and I'm doing it / not doing it.
7. Other _____

Please explain your answers as necessary. _____

_____

_____

What nutritional supplements are you taking currently, / where are they from?

_____

_____

_____

What tests were performed to determine the supplements you're taking?

_____

_____

_____

Name_____Date_____

Dr. Stan Gale

http://DrStanGale.com

1920 Allesandro Street
Los Angeles, Ca. 90039

(323) 663-7736

Privacy Disclosure

Our Pledge Regarding Your Identity and Medical Information.

We create a record of the care and services you receive at this office. We need this record to provide you with quality care. We understand that medical information about you and your health is personal, and we are committed to protecting your identity as a patient and the medical information about you.

However, there may be instances where your identity and or medical information may be disclosed without your prior authorization. This notice will tell you about the ways in which we may use and disclose medical information about you:

For Treatment: Your name and medical information is given to the doctor and appropriate staff who work at Gale Chiropractic for the purpose of providing you with treatment.
Mail: Often postcards are sent out addressed to you from Gale Chiropractic. The postcard content may indicate you are a patient. This information may be seen by postal personnel and other members of your household.
E-Mail: You may be involved with communication back and forth by e-mail with Dr. Gale regarding your health questions. This information may be exposed to others who have access to your e-mail.
Open Room We will be treating you in our open room in view of other patients. There is a private treating room always available to you.
Folders: We take every precaution to insure only authorized staff have access to your patient folder and its contents. Your name, however, is clearly written on the folder. These folders are on a standing divider in clear sight next to Dr. Gale as he treats. At times your file may lie on the receptionists desk. In these instances your file with your name may be in view of other patients. File drawers are not locked.
In Emergencies: (such as being sent from here to a hospital), we may tell your relevant family or friends your condition and that you are in the hospital.
Gale Chiropractic Business Associates: There are independent contractors who may come to this office and may be exposed to patient identity and/or information. The associate, such as someone who does computer repairs, data entry etc. must sign a business associates agreement not to disclose patient identity or information to anyone.
As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.
In Response to a Court Order: such as a subpoena, warrant, summons or similar process.
Authorization: Disclosures, other than those described above, will be made only with your written authorization

_____

Signature and Date

Dr. Stan Gale

http://DrStanGale.com

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Los Angeles, Ca. 90039

(323) 663-7736

Your rights regarding medical information.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information, you must submit your request in writing to Gale Chiropractic.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask to amend the information. To request an amendment, your request must be made in writing and submitted to Gale Chiropractic. Your request may be denied if the information is accurate and complete or if the information was not created by us.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you. To request a list of disclosures, you must submit your request in writing to Gale Chiropractic.

Right to Request Restrictions. You have the right to request a restriction or limitations on the medical information we use disclose about you for treatment, payment or health care operations. We will comply with your request unless the information is needed to provide you emergency treatment.

Involved in Your Care: You have the right to request a limit on the medical information we disclose about you to someone who is involved in taking care of you while you are convalescing

Payment of Your Care: You have the right to request a limit on the medical information we disclose about you to someone involved in the payment of your care.

To Request Restrictions: you must make your request in writing to Gale Chiropractic. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. To request confidential communications, you must make your request in writing to Gale Chiropractic.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes to this Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the office manager of Gale Chiropractic and we will work it out. If you're not satisfied with the resolution, you can file a complaint with the Secretary of the Department of Health and Human Services.

Signature and Date

Dr. Stan Gale

http://DrStanGale.com

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Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy for me (or on the patient named below, for whom I am legally responsible) by Dr. Stan Gale, or other licensed Doctor of Chiropractic who in the future may treat me while employed by, working or associated with or serve as back-up for Dr. Stan Gale. I have had an opportunity to discuss with Dr.Gale the nature and purpose of chiropractic adjustments and other procedures. I have read and understand the below:

Following are known risks: Temporary soreness or increased symptoms or pain. It's not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify your chiropractor if you experience these symptoms before or after your care. Fractures. When a patient has an underlying condition that weakens bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with bone weakening diseases or conditions. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. Disc herniation. Spinal disc conditions like bulges may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. Stroke. A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke. The incidences of these strokes are estimated to be between one in one million and one in five million neck adjustments. This is exactly the same statistic as the number of people who have stroke symptoms when they're at their hairdresser.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

Signature and Date

Scheduling Policy

We strive to have a no-wait office. To ensure you and all our patients get the best treatment and are seen on time, please observe the following policy.

Please make a 24 hour advanced notice if you need to change your appointment. It takes that amount of time to make arrangements with other patients who need care and may take your place.

Be on time. There is ample time for your treatment as long as it is not cut short by lateness. Give yourself sufficient time to get to your appointment. This is Los Angeles and the traffic can be unpredictable.

If you can't predict your schedule, our office will contact you between 1:00 and 2:00 on the day you want to come in to see what appointment time is available for you.

There is a $25 missed appointment fee for changing/canceling your appointment without a 24 hour notice. Keep in mind that coming in 10 minutes late for your appointment does not leave enough time for a treatment and a missed appointment fee will apply.

Please check off the appointment arrangements you would like.

_____Schedule appointments ahead, be on time, and give at least a 24 hour notice for appointment changes.

_____Instead of scheduling ahead, our office will call you on the day you would like to be seen to see what may be available for you.

I have read, understood and agree to follow the above policy.

Signature_____Date_____

Dr. Stan Gale 1920 Allesandro Street Los Angeles, Ca. 90039 (323) 663-7736

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone Number_____

Work Phone_____

Pager or cell_____