Chris Tsai, DC, DACBSP
Doctor of Chiropractic
DIPLOMATE OF AMERICAN CHIROPRACTIC BOARD OF SPORTS PHYSICIANS

PATIENT INFORMATION

Name____ Birth date__________________ Age___________

Address ____ Cell phone _________________________

City_____________________ State _______ Zip Code __________ Home Phone ______________________

E-mail ____

Employer's Name ____ Position ____________________________

Marital status – *circle one* [S M W D] Are You Insured? [Y N] Ins. Company ____________________

Spouse's name ___________________ Are you Pregnant? [Y N] Number of children _____________

Referred by ____

Have you had chiropractic care before? ____________**When?**____

What is your current complaint? ____

Is this condition due to:

☐ Auto accident ☐ Work injury
☐ Other accident ☐ Illness
☐ Unknown cause

Date symptoms appeared

____

Are symptoms:

☐ Improving
☐ About the same
☐ Getting worse
☐ Intermittent [come and go]

Have you had these symptoms Before?

☐ No
☐ Yes When? ___________________

Check any activities which aggravate your condition:

☐ Standing ☐ Lying
☐ Bending ☐ Coughing
☐ Twisting ☐ Walking
☐ Sitting ☐ Lifting

Other health issues not chiropractic issues:

____
____
____

List all previous accidents:

____
____
____

List all prescription drugs you now take:

____
____
____
____

List all non- prescription drugs you now take:

____
____
____

Check here if you

☐ smoke
☐ don't exercise regularly

Are you allergic to any medications? ☐Yes ☐No **If yes, please list:** __________________________________

Who is your general practitioner? Dr. ____

List all surgical operations:

____

____

Check here if you have a family history of :

☐ arthritis
☐ cardiovascular disease
☐ diabetes
☐ cancer

Please check the type of care desired so that we may be guided by your wishes when possible:

[ ] Temporary relief [ ] Control of immediate problem [ ] Total healthcare [ ] I prefer the Dr. to select the type of care he feels is best for me

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Patient Name:____ **Date:**________________________________

Date of Accident: _____________________Hour __________ AM __ PM __ Location _________________________

How did Accident Occur? □ Auto Collision □ On-the-Job Injury □ Other __________________

If not an auto collision, please describe the circumstances:

____

Did you report the injury to your foreman or employer □ YES □ NO

Did he (they) recommend care at our office? □ YES □ NO

If auto accident, were you: □ Driver □ Passenger □ Pedestrian

Type of your vehicle:____

Type of vehicle that hit you:____

If auto collision, were you struck from: □ Behind □ Right Side □ Left Side □ Front □ Auto was Parked

Did your car strike the other(s) involved? □ YES □ NO

OR did the other car strike yours? □ YES □ NO □ UNDETERMINED

As a result of the accident, were traffic citations issued to you? □ YES □ NO

To the driver of the other car? □ YES □ NO To the driver of your car? □ YES □ NO

Your approximate speed: ________mph Other vehicle approximate speed: ________mph

Seatbelt: □ YES □ NO Looking straight/Right/Left Hands on steering: Left/Right/None

Did you see the accident coming before the impact? □ YES □ NO

What occurred at the moment of impact? (Check ALL that apply)

□ Tensed body for impact □ Neck whipped backward & forward □ Thrown from side to side

□ Body torqued & twisted □ Thrown from the vehicle □ Pinned in vehicle □ Bruised □ Cut

List the extent of the injuries as you know them

____

Did you require post-accident hospitalization? □ YES □ NO Were you unconscious? □ YES □ NO

List hospital/ER/Urgent Care:________________________________ Any X Rays/Images taken? □ YES □ NO

Check symptoms you have noticed since accident:

□ Headache	□ Dizziness	□ Light Bother Eyes	□ Diarrhea
□ Neck Pain	□ Head Seems Too Heavy	□ Loss of Memory	□ Feet Cold
□ Neck Stiff	□ Pins and Needles in Arms	□ Ears Ring	□ Hands Cold
□ Sleeping Problems	□ Pins and Needles in Legs	□ Face Flushed	□ Stomach Upset
□ Back Pain	□ Numbness in Fingers	□ Buzzing in Ears	□ Constipation
□ Nervousness	□ Numbness in Toes	□ Loss of Balance	□ Cold Sweats
□ Tension	□ Shortness of Breath	□ Fainting	□ Fever
□ Irritability	□ Fatigue	□ Loss of Smell	□_________
□ Chest Pain	□ Depression	□ Loss of Taste	□_________

Symptoms other than above ____

Have you lost any days of work? □ YES □ NO Dates: ________________________

Patient Name:____ Date:__________________________

Insurance Companies involved:

My Company____

Company of person responsible for injuries? ____

Have you been contacted by an insurance adjuster or company representative regarding this claim?

☐ YES ☐ NO

Amount of damage to your vehicle $______________________________________

☐ Minor Damage ☐ Moderate Damage ☐ Total Loss

Amount of damage to the other vehicle $______________________________________

☐ Minor Damage ☐ Moderate Damage ☐ Total Loss

Do you have an attorney that has advised you in this care? ☐ YES ☐ NO

Attorney Name:____

Mailing Address:____

Phone Number:____

Fax Number:____

Ref/Claim Number:____

Patient Name:____

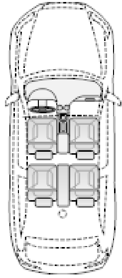
Date of Injury: :____

Date of Birth: :____

____________________________	__________________________________	____________
Patient Name	**Patient Signature**	**Date**

Patient Name:_______________________________________ **Date:**________________________

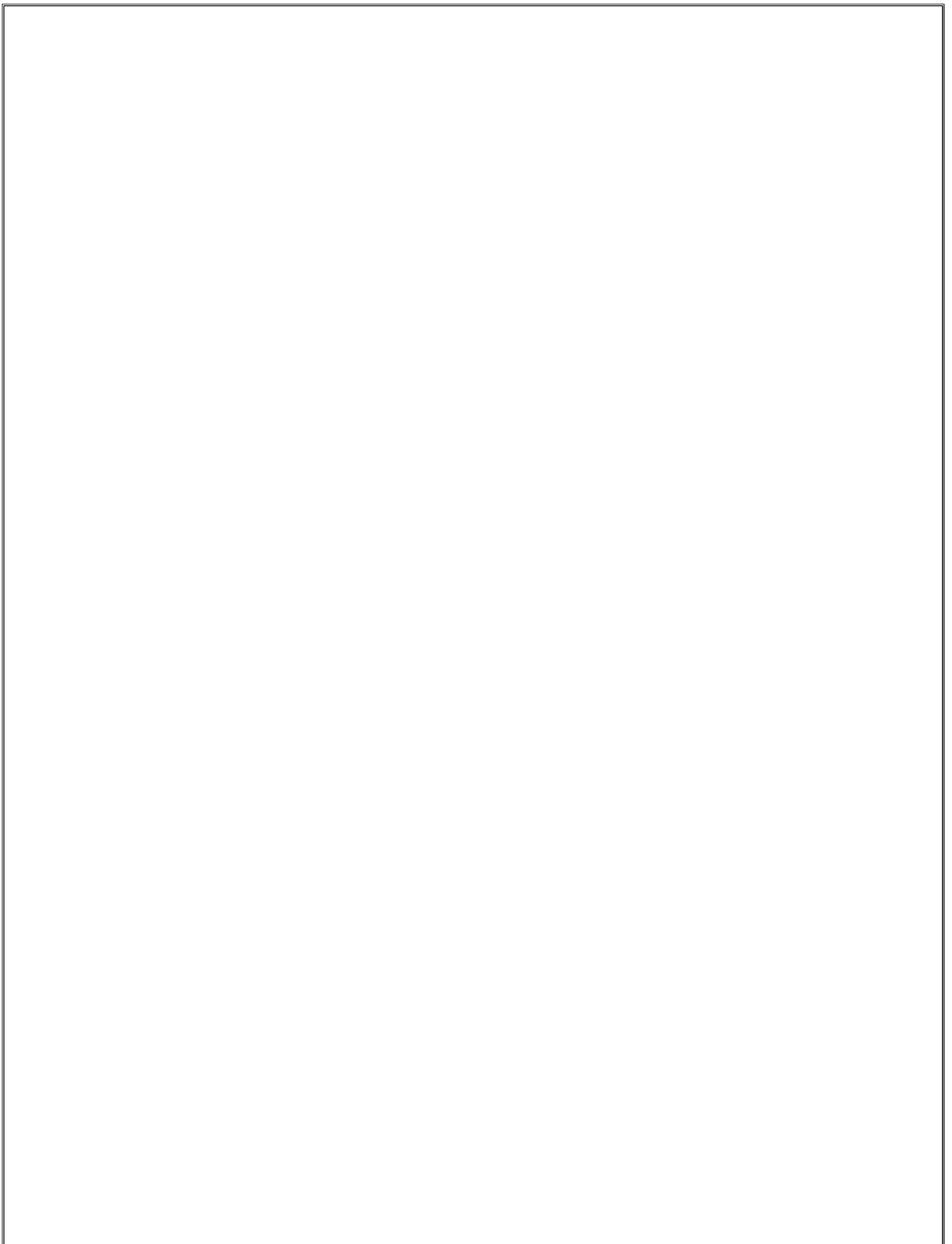
Diagram of Injury



Date of Accident:______________________

Description of Accident

How you feel immediately after the accident?



Dr. Chris CSI
Chiropractic Sports Injuries

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ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with____ and assign directly to Dr Christopher Tsai, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____

Signature of Patient, Parent, Guardian or Personal Representative Date

____

Please print name of above signature Relationship to Patient

X-Ray Consent

I hereby give my consent to Dr Chris Chiropractic Care and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

___________________________________ _________________________

Patient Signature Date

Clinical Summary (a required EMR question)

___ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Affidavit

I, the undersigned, declare as follow:

1. That at the accident occurring the _____________ day of _____________, 20_______, in the vicinity of ____________________________, I was present in the vehicle involved, and I sustained injuries as a result of said accident.

2. I further declare that prior to the accident; I had no knowledge regarding the driver of the other vehicle involved.

3. I understand that according to the laws of State of California bringing of a fraudulent claim is crime punishable by imprisonment and/or fine, and that I declare that the above mentioned accident was not fraudulent in any manner

4. I have read and understood the foregoing.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this _______________ day of _________________________ , 20__________

____ ____

Patient Name **Patient Signature**

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ATTORNEY-PATIENT LIEN AGREEMENT TO PAY DOCTOR

TO: LAW OFFICE OF ____

____

____

RE: MEDICAL REPROTS AND DOCTOR'S LIEN

PATIENT: ____DATE OF ACCIDENT: ___________________________

I do hereby authorize the above clinic to furnish you, my attorney, with a full report of his examination, diagnosis, treatments, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said clinic (doctors) such sums as may be due and owing him for medical service rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said clinic (doctors). And I hereby further give a Lien on my case to said clinic (doctors) against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said clinic (doctors) additional protection ad in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said clinic (doctors) of any change or additions of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by singing below and returning to the clinic. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, teh doctor will not await payment but may declare the entire balance due and payable.

DATED:______________________PATIENT SIGNATURE:____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said clinic (doctors) name above. Attorney further agrees that in the event this lien or the underlying debt is litigated, the prevailing party will be awarded reasonable attorney's fees as well as costs.

DATED:______________________ATTORNEY SIGNATURE:____

Attorney: please date, sign and return one copy of this lien to doctor's office at once. Reply envelope attached. Keep one copy for your records.

DATED:______________________DOCTOR SIGNATURE:____

Mail: 4021 W Burbank Blvd.
Burbank, CA 91505

301 W Huntington Dr #217
Arcadia, CA 91007

Fax: Burbank: 818-848-7701
Arcadia: 626-445-0127

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Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me whole employed by, working or associated with or serving as back up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with the office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. The doctor will use his/her hands or a mechanical device to manipulate the area treated. I may feel or hear a "click" or "pop" and may feel movement. Chiropractic treatment also includes activity advices, exercise, hot/cold packs or electric stimulation. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, irritation of nerves or spinal cord or in rare incidences death. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure to which the doctor feels at the time, based upon the facts then known, is in my best interests. I will inform my chiropractor of all medications I am taking, including blood thinners, any surgeries I have had, and any other medical conditions I have, including osteoporosis, heart disease, cancer, stroke, fracture of previous severe injuries.

I further understand that there are treatment options available for my conditions other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and pain-killers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, 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.

Cancellation Policy. Please call 24 hours in advance for any cancellations or to reschedule, otherwise you will be charged for a missed appointment. The charge for missed appointment is your responsibility and not billable to your insurance carrier. If you are late to your scheduled massage, you will only receive the remaining time of the appointment but will be responsible for full payment.

Patient Name	**Patient Signature**	**Date**
Doctor Name	**Doctor Signature**	**Date**

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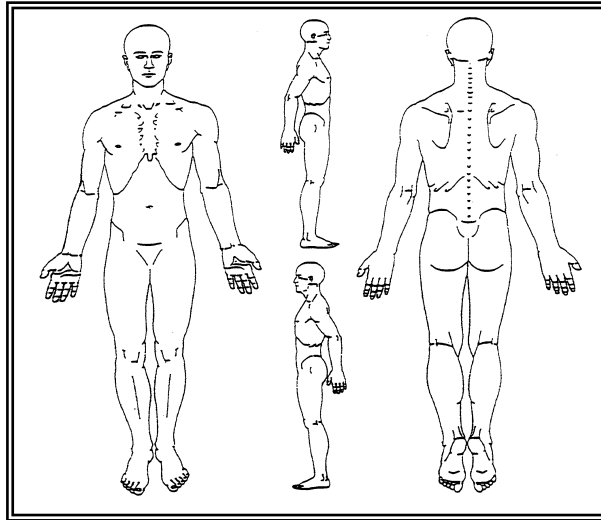
Please indicate the main reason you are seeing us today:

____

If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, CIRCLE the pain level you experience when your problem is at its very worst:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? _____________ **Is there any numbness or tingling?** _______________

How often do you experience your problem? (Please indicate for each of the body location if applicable)

Constant (75 – 100% of the time) ____

Frequent (50 – 75% of the time) ____

Occasional (25 – 50% of the time) ____

Intermittent (0 – 25% of the time) ____

what tests have you already had for this problem? ☐X-rays ☐MRI ☐C.T. Scan ☐Myelogram ☐EMG/NCV ☐None ☐Other

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following:

*Exercise*_______ *Sleep* _______ *Diet* ________ *Stress Level* ______ *Water Intake* _______ *Energy Level*_________ = __________

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REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days: 0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head:
______ Headaches
______ Faintness
______ Dizziness
______ Insomnia

Energy/Activity:
_____ Fatigue/Sluggishness
_____ Apapthy/Lethargy
_____ Hyperactivity
_____ Restlessness

Lungs:
_____ Chest Congestion
_____ Asthma, Bronchitis
_____ Shortness Of Breath
_____ Difficulty Breathing

Eyes:
_____ Watery or Itchy Eyes
_____ Swollen, Red or Sticky Eyelids
_____ Bags or Dark Circles Under Eyes
_____ Blurred or Tunnel Vision (not including near or far sightedness)

Weight:
_____ Binge Eating/Drinking
_____ Craving Certain Foods
_____ Excessive Weight
_____ Compulsive Eating
_____ Water Retention
_____ Underweight

Heart:
_____ Irregular or Skipped Heartbeat
_____ Rapid or Pounding Heartbeat
_____ Chest Pain

Ears:
_____ Itchy Ears
_____ Earaches, Ear Infections
_____ Drainage From Ear
_____ Ringing In Ears, Hearing Loss

Emotions:
_____ Mood Swings
_____ Anxiety/Fear/Nervousness
_____ Anger/Irritability/Aggressiveness
_____ Depression

Digestive Tract:
______ Nausea, Vomiting
______ Diarrhea
______ Constipation
______ Bloated Feeling
______ Belching, Passing Gas
______ Heartburn
______ Intestinal/Stomach Pain

Nose:
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucus Formation

Mind:
_____ Poor Memory
_____ Confusion, Poor Comprehension
_____ Poor Concentration
_____ Poor Physical Condition
_____ Difficulty Making Decisions
_____ Stuttering or Stammering
_____ Slurred speech

Mouth & Throat:
_____ Chronic Coughing
_____ Frequent Need to Clear Throat
_____ Sore Throat, Hoarseness
_____ Swollen or Discolored Tongue
_____ Canker Sores

Other:
______ Frequent Illness
______ Frequent or Urgent Urination
______ Genital Itch or Discharge

Skin:
_____ Acne
_____ Hives, Rashes, Dry Skin
_____ Hair Loss
_____ Flushing, Hot Flashes
_____ Excessive Sweating

Joints/Muscles:
_____ Pain or Aches in Joints
_____ Arthritis
_____ Stiffness or Limited Movement
_____ Pain or Aches in Muscles
_____ Weakness or Fatigued Muscles

Grand Total:

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REQUEST FOR RECORD RELEASE

DATE: ______________________

TO: ____
DOCTOR OR HOSPITAL NAME

ADDRESS: ____
HOSPITAL OR DOCTOR ADDRESS

FROM: ____

PATIENT NAME: ____
First M Last

DATE OF BIRTH: ____

I HEREBY AUTHORIZE AND REQUEST YOUR FACILITY TO RELEASE THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD.

FROM_______________________TO PRESENT TO THIS OFFICE:

Dr Chris CSI - Chiropractic Sports Injuries

4021 W Burbank Blvd.
Burbank, CA 91505
Tel: 818-841-4100
Fax: 818-848-7701

301 W Huntington Dr #217
Arcadia, CA 91007
Tel: 626-445-2536
Fax: 626-445-0127

Patient Signature:____