Date ___________

New Patient Health Questionnaire

Please print legibly and fill this out completely and thouroughly. The more you tell us, the more we will understand your problem and be able to target the cause and access how we can help you.

Name: ______________________________________ Age: ____ Date of Birth ____ / ____ / ________

Address: ____________________________________ City _________________________ Zip _____________

Phone:( ) ________________ Email: ______________________________ SS# ________________________

Height: _____ Wt: ______lbs. Handed L R A ☐ Male ☐ Female Marital Status: M S D W ___

Emergency Contact: Name ____ Ph _____________________

Occupation? ____How were you referred? ___________________

Any Previous Chiropractic Care: Y N ____

Is condition due to: ☐ Home Accident ☐ Work Injury ☐ Auto Accident ☐ Sports Injury ☐ Other ________

Present Complaints: (New) ____

____

Have you had this or a similar condition in the past? Y N When: ___________________________________

Other doctors seen for this condition: ☐ DC ☐ MD ☐ Other Mo & Yr: ________ Meds prescribed? Y N

When was the last visit with them? (Mo./ Yr)___________ Any results? Y N

Have you had any X-rays, MRIs, CAT Scans or other diagnostic tests performed within the last 12 mo. Y N

Findings: ____

Is your pain: ☐ Constant ☐ Frequent ☐ Intermittent (comes and goes) ☐ Occasional ☐ ____________

On a scale of **1 to 10** and 10 being worse, what is your **pain level today?** ______

Problem is getting? ☐ Worse ☐ Better ☐ Staying the same ☐ Recurring flair-up ☐ Comes and goes

What makes it worse?____

What makes it better? ____

What have you been doing for it up until now? ____

Check line below if you've had any of the following within the past 6 months and circle Lt or Rt where indicated

__ Neck Pain
__ Headaches Freq.
__ Arm Pain Lt Rt
__ Numb Arms/Hands Lt Rt
__ Numbness in Fingers Lt Rt
__ Shoulder Pain Lt Rt
__ Low Back Pain
__ Leg Pain Lt Rt
__ Numbness in Legs Lt Rt
__ Sciatica L R
__ Difficulty Urinating
__ Digestive Disorders
__ Pain Between Shoulders
__ Difficulty Breathing
__ Asthma
__ Upper Back Pain
__ Allergies
__ Skin Conditions

Please check below

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Cigs/Packs/Day___________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ____________
☐ Daily	☐Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _______________
☐ Heavy	☐Heavy Labor		

Do you have any metal implants anywhere in your body? (Pins, screws, pacemaker) Y N if yes, describe

____

Drugs you are now taking and what they're for: ____

____

Are you pregnant? Y N

Your general health is: ☐Excellent ☐Good ☐Fair ☐Poor ☐Medication Dependent

Describe **any** other condition/disease you have been diagnosed with or are being treated for other than which you are consulting us for today: ____

PLEASE DO NOT TAKE THE QUESTIONS BELOW LIGHTLY. THEY ARE VERY IMPORTANT FOR YOUR EVALUATION

History

Injuries/Surgeries	Detailed Description and Date (YR) of Occurrence
Falls	____
Head Injuries	____
Broken Bones	____
Dislocations	____
Other ____	

Certification and Assignment

I certify that the above information is complete, correct and accurate. I also understand that it is my responsibility to inform my doctor if I or my minor child being treated in this office has a change in health.

I assign directly to Chris A. Hawn, D.C. 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. Chris A. Hawn, D.C. may use my health care information and may disclose such information to Insurance company(s) that I have provided as well as their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand and agree that some insurance companies send insurance proceeds directly to and made out to the insured. I accept and understand that should that occur, I am responsible for forwarding payment for those proceeds along with a copy of the explanation of benefits directly to Chris A. Hawn, D.C. within 10 days of receiving them. The mailing address for payments is Chris Hawn, D.C. 24551 Del Prado Ste. 518 Dana Point CA 92629. Upon receipt, those proceeds will be directly credited to my account. This consent will not end until my current treatment plan is completed or two years from the date signed below.

____

Signature of Patient, Parent, Guardian or Personal Representative

____

Please print name of Patient, Parent, Guardian or Personal Representative

Date __/____/____ Relationship to Patient _______________________

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 who 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 while employed by working or associated with or serving as backup 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 and have had the opportunity to discuss with the doctor of Chiropractic named below and/or with other office or clerical Personnel the nature and purpose of Chiropractic adjustments and procedures 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 strains and sprains. 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 which the doctor feels at the time, based on the facts then known is in my best interest.

I further understand that there may be treatment options available for my condition other than Chiropractic procedures. These treatment options include but are 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. By signing this I understand and I have been informed that I have the right to a second opinion and to secure other options 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 the opportunity to ask questions about its content and by signing below I agree to the above and procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

CHIROPRACTORS NAME: Chris A Hawn, D.C.

PATIENT SIGNATURE: ______________________________ PRINT NAME:______________________________
DATE: ______________________________

(Or Guardian/Parent/Representative) (Provide name and relationship if signing for patient)

Arabitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not be a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.
Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court of action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but no limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of the first professional services.
If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature: ____ Date : ______________________
Print Name:

Office Signature: Chris A Hawn, D.C. Date: ________________________