# PATIENT INFORMATION SHEET

**TODAY'S DATE:** _____ **DATE OF INJURY:** _____

**Last Name** _____ **First Name** _____ **Middle**_____

**HOME ADDRESS:**
**Street**_____ **Apt. #**_____

**City**_____ **State**_____ **Zip**_____

**Social Security Number:** _____ **HOME PHONE:** ___ _____

**CELL:** ___ _____ **WORK PHONE:** _____

**DRIVER'S LIC. NO:** _____ **BIRTH DATE:** _____

**Sex: M ( ) F ( )** **Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced**

***IN CASE OF EMERGENCY PLEASE NOTIFY:***

**Last Name:** _____ **First Name:** _____ **Phone: (___)**_____

**Address:** _____

_____

**ATTORNEY:** _____

**PHONE:** _____**FAX:**_____

**ADDRESS:** _____

**EMPLOYER:** _____ **PHONE: (___)**_____

**PRIVATE HEALTH INSURANCE CO. :**

_____

**ADDRESS:** _____

**POLICEY NO.:** _____ **GROUP:** _____

**SUBSCRIBER/RELATIONSHIP:** _____

**AUTO INSURANCE COVERAGE:** _____**PHONE: (___)**_____

**ADDRESS:** _____

**POLICY NO.:** _____ **SUBSCRIBER/RELATIONSHIP:**_____

# PATIENT HISTORY FORM

**TODAY'S DATE: _____ INJURY DATE: _____**

**NAME OF PATIENT: _____ AGE: _____**

**SEX: ( ) Male ( ) Female ( ) Right-Handed ( ) Left-Handed**

**Occupation:_____**

**NATURE OF ACCIDENT:**

**( ) Motor Vehicle ( ) Slip and Fall ( ) Pedestrian ( ) Work Related**

**If Non-Motor Vehicle Accident, describe the injury**:_____

_____

_____

**Motor Vehicle Accident Information Only:**

**Patient was the: ( ) Wearing seatbelt ( ) Not wearing seatbelt**

**( ) Driver ( ) Passenger in ( )**Right front seat ( ) Rear (middle left right seat) ( ) Other**:_____**

**Patient's vehicle:** ( ) Auto ( ) SUV ( ) Van ( ) Pick-up Truck ( ) Motorcycle ( ) Other_____

**Versus:** ( ) Auto ( )SUV ( ) Van ( ) Pick-up Truck ( ) Motorcycle ( ) Other _____

**Patient's vehicle was:** ( ) at a stop ( ) moving _____

**When it was struck** ( ) From Behind ( ) Head on ( ) On the side ___Right _____Left

( ) Other_____

**During the Impact, the Air bags were** ( ) deployed ( ) DID NOT deploy

**On Impact, the patient was:**

( ) unprepared ( ) had head turned to __ right ___left ___rear

( ) braced for impact ( ) stepped hard on brakes ( ) forcibly held on to steering wheel

**Due to the force of the impact, the patient was:**

( ) Jolted back and forth ( ) Jolted forward and back ( ) Jolted from side to side

( ) other_____

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**The patient:** ( ) Denied loss of consciousness

( ) Lost consciousness… ( ) momentarily ( ) several minutes _____

**During impact, the patient struck:**

Area of body _____ Against_____

Area of body _____ Against_____

**Patient felt:** ( ) Nervous ( ) Shocked ( ) Dazed ( ) Stunned ( ) Dizzy ( ) Confused
( ) Disoriented ( ) Scared ( ) Panicky ( ) Lightheaded ( ) Nauseated
( ) Other _____

**Patient also experienced:** ( ) NO Vomiting ( ) Vomiting_____

**Patient sustained:**
( ) Bleeding / lacerations / Cuts:_____

( ) Bruises / Airbag burn_____

**Patient noted pain: ( ) Immediately following the accident ( ) _____Min/ Hours later**
**( ) The next day ( ) Over the next _____few days**

**( ) Neck ( ) Upper back ( ) Mid back ( ) Lower back ( ) Chest ( ) Abdomen**
**( ) Headaches**

| | | | |
|---|---|---|---|
| **( ) Shoulder** | **( ) right ( ) left** | **( ) Arm** | **( ) right ( ) left** |
| **( ) Elbow** | **( ) right ( ) left** | **( ) Wrist** | **( ) right ( ) left** |
| **( ) Hand** | **( ) right ( ) left** | **( ) Fingers** | **( ) right ( ) left** |
| **( ) Hip** | **( ) right ( ) left** | **( ) Thigh** | **( ) right ( ) left** |
| **( ) Knee** | **( ) right ( ) left** | **( ) Leg** | **( ) right ( ) left** |
| **( ) Ankle** | **( ) right ( ) left** | **( ) Foot** | **( ) right ( ) left** |
| **( ) Toes** | **( ) right ( ) left** | | |

**( ) Other _____**

**Treatment / Self Remedy_____**

**( )After the Accident ( ) Hours later ( ) The next day ( ) Date _____**

**( ) Patient was taken ( ) Went to… Hospital / Urgent care via… ( ) paramedics ( )Self/ Family member**

**Name of Hospital/Medical Center _____**

**Treatment rendered at hospital/center/Self Remedy_____**

_____

_____

**Other treatments:**

**Dr._____**

**Treatment received_____**

**Dr._____**

**Treatment received_____**

**Other_____**

# Current Complaints

**Headaches:**
**Pain is rated:** /10 ( No Pain =0 to Severe pain = 10 )
**Frequency:** ( ) Constant ( ) Frequent ( ) Intermittent ( )Occasional
**Nature:** ( ) Dull ( ) Sharp ( ) Throbbing ( ) Pressure-type
( ) Other_____
**Location:** ( ) all over the head ( ) frontal area ( ) Back of head ( ) Top of head ( ) Temples on right./ Left

| | | Frequency | Intensity |
|---|---|---|---|
| **( ) Chest/Rib/Abdomen** | | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Neck pain** | | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Upper/mid back pain** | | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Lower back pain** | | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Shoulder pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Upper arm pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Elbow pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Forearm pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Wrist pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Hand pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Finger pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Hip pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Thigh pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Knee pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Lower leg pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Ankle pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Foot pain** | **( )R ( ) L** | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |
| **( ) Other**_____ | | ---Constant—-Frequent—-Intermittent | Minimal to Slight to Moderate to Severe |

**Pain is Rated:** **( No Pain =0 to Severe pain = 10 )**
**0 1 2 3 4 5 6 7 8 9 10**

**Describe any Radiating pain:**

From neck down to ---Right --- Left Shoulder, Arm, Elbow, Forearm, Hand- Fingers

From lower back to ---Right --- Left Buttocks, Thigh, Knee, Leg, Ankle, Foot

**Describe any Numbness / Tingling sensations:**

From neck down to ---Right --- Left Shoulder, Arm, Elbow, Forearm, Hand- Fingers

From lower back to ---Right --- Left Buttocks, Thigh, Knee, Leg, Ankle, Foot

**Bruises:**_____ **Swelling:**_____
**Abrasions**_____ **Cuts/ Laceration**_____

**( ) Limping due to pain in…** ( ) right ( ) left _____ ( ) other _____
**( ) Unable to find a comfortable position in bed due to pain.**

**Mark any of the following associated complaints:**

( ) Blurred Vision ( ) Nausea/Vomiting ( ) Loss of Balance ( ) Dizziness ( ) Memory Loss
( ) Loss of Appetite ( ) Nervousness ( ) Anxiety ( ) Tension ( ) Trouble Sleeping
( ) Restlessness ( ) Bladder / Bowl Problems ( ) Ringing Noise in the Ears ( ) Other_____

**Activities that increase patient's symptoms: ( ) ALL General daily activities ( ) Work Activities**

( ) Flexing/Bending ( ) Carrying ( ) Lifting ( ) Laying down ( ) Getting up from seated position
( ) Pushing ( ) Pulling ( ) Squatting ( ) Walking ( ) Prolonged activities
( ) Sitting ( ) Driving ( ) Reaching Overhead ( ) Working on computer
( ) Standing ( ) Coughing ( ) Sneezing ( ) Other_____

**Since the accident; Symptoms have:** ( ) Improved ( ) Remained the Same ( ) Worsened

## PAST MEDICAL HISTORY

**Medical Illness: ( ) None ( ) Yes (Treatment):**

**Kidney** _____ **Asthma** _____
**Cancer** _____ **Diabetes** _____
**HIV** _____ **Tuberculosis** _____
**Lung** _____ **Psychiatric** _____
**Kidney** _____ **High Blood Pressure** _____
**Other** _____ Treatment: _____

**Surgical History: ( ) None ( ) Yes (Date):**

**Appendectomy** _____ **Gallbladder** _____
**Herniotomy** _____ **Hysterectomy** _____
**Heart/Bypass** _____ **Tonsillectomy** _____
**Other** _____

**Medications: ( ) None ( ) Yes:**

_____

**Allergies: ( ) None ( ) Yes To ?_____( ) Unknown**

**Previous Accidents/Injuries: ( ) None ( ) Was Asymptomatic ( ) Yes**

Auto Accidents: _____( ) Recovered

Auto Accidents _____ ( ) Recovered

Slip and Fall:_____( ) Recovered

Work-related: _____ ( ) Recovered

Fractures or other traumas: _____ ( ) Recovered

**Social History:**

**Alcohol Intake:** ( ) Does not drink ( ) Drinks…… ( ) Occasionally ( ) Socially ( ) Rarely

**Tobacco Use:** ( ) Non Smoker ( ) Smoker _____Cigarettes/ packs per Day /Week for ___Years

**Pregnant:** ( ) NO ( ) YES How many months? _____ Expected date of delivery_____

# Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while 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.

I have had an opportunity to discuss with the doctor of chiropractic named below and / or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I 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 and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complication, 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 upon the facts then known, is in my best interests.

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.

---

_____ _____

**Print Patient's Name** **Print Name of Patient's Guardian/Parent**

_____ _____

**Signature of Patient** **Signature of Patient's Guardian of Parent**

_____ _____

**Date Signed**

**As: _____**

***Relationship or authority of Patient's Representative***

# RESPECTING THE PRIVACY OF OUR PATIENTS

We value the trust of our patients and deeply committed to protecting the privacy of patient information. That is why we only collect and disclose information necessary to provide our patients with quality services. We welcome this opportunity to describe the steps we take to protect our patient's information. Our goal is to ensure that you fully understand our policies and practices regarding the collection, disclosure and protection of this information. You will receive a copy of our privacy statement at the beginning of our doctor-patient, or at your next visit for established patients. The privacy policies described in this statement apply to our current and former patients. It may be necessary to review and revise our privacy policies, in which case we will provide and updated privacy notice.

**Information we collect.** In order to provide high quality services, we must collect and often share information about you and individuals covered under your insurance policy that is not publicly available. We do this to better service patients and process claims in a timely manner. We collect and may share the following types of information about you and your family covered under your policy: 1) Information about the identity of you and individuals covered in your policy, including the names, addresses, and social security numbers of such individuals. 2) Information we receive from you on applications or other insurance and account forms, such as the claims history or medical history of individuals covered under your policy. 3) Information about your transactions and experiences with us, such as the treatments you received from us, your payment history, account balance, and amounts you paid for your care.

Should we need to verify or obtain additional information about you or individuals covered under your policy, we may contact outside resources, such as agents, brokers, administrators, insurance support organizations, consumer reporting agencies, medical providers and government reporting agencies. Information collected from these outside sources may include employment information and claims or medical reports. Information obtained from outside sources may be retained by these outside sources and disclosed to other persons, in accordance with applicable laws.

**How Such Information is Used.** In many cases, it is necessary to share some or all of the information listed above to help us deliver the best possible services to you and individuals covered under your policy. These disclosures are often necessary to fulfill transactions you have requested and to service the insurance policies that you have applied for and/or purchased. For example, we may share information with your insurance agent or broker, claims adjusters and administrators, claims investigators, and outside companies that perform administrative services on our behalf. We may share information about you and individuals covered under your policy to comply with legal and regulatory requirements and for other limited purposes that are required or permitted by law. For example, we may share information about you and individuals covered under your policy to:

1) Process a transaction that you request.
2) Protect against fraud or criminal activity.
3) Report account activity to credit bureaus.
4) Comply with local, state or federal laws.
5) Provide information requested by enforcement agencies. Reinsurers, state insurance regulators and self-regulatory organization, insurance support agencies and law. Under no circumstances do we shall or share patient information to any outside party.

**Access to and Correction of Individual Information.** Individuals covered under your policy may write to is if they have any questions about the information that we may have in our records about them or the identity of those persons to whom their information was disclosed during the two years prior to their request. If they wish, they may review this information in person or receive a copy ay a reasonable charge. Individuals covered under you policy can notify us in writing if they believe any information should be corrected, amended, or deleted, and we will review their request. We will either make the requested change or explain why we didn't do so. If we do not make the requested change, they may submit a short written statement identifying the disputed information, which will be included in all future disclosures of their information.

**Confidentiality and Security of Information.** We dedicate significant resources to protect the security of our patient information. We restrict access to customer information to those individuals who need to know that information to provide to services to you or individuals covered under your policy. We also maintain physical, electronic, and procedural safeguards to protect patient information and guard against its unauthorized use.

PRINT NAME: _____

SIGNATURE: _____DATE: _____

# HENRIK DILANCHIAN, DC
## PHYSICIAN-PATIENT ARBRITATION 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 law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of nay of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

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 of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of 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 or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court 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 California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: 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 California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered by the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

| _____ | _____ | _____ |
|---|---|---|
| Date | Patient's Signature | Print Name |

# Henrik Dilanchian, DC

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 CONTACT.**

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Physician: Henrik Dilanchian, DC

Date: _____

Signature: _____

# DOCTOR'S LIEN

**Doctor:**
Dilanchian Chiropractic Corp.
**Address:**
409 S. Central Ave
Glendale, CA 91206
**Tel:** (818) 247-1331
**Fax:** (818) 247-1332

**Regards To Patient:**

I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/ illness which occurred/ began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/ illness, and authorize and direct you, my attorney/ insurance carrier, to pay directly to said such sums as may be due and owing him for services rendered to me, and to withhold such sums from such I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may recover said fees.

Dated: _____Patient's Signature: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and agree to honor the same to protect adequately said above named doctor.

Dated: _____Authorized Signature: _____