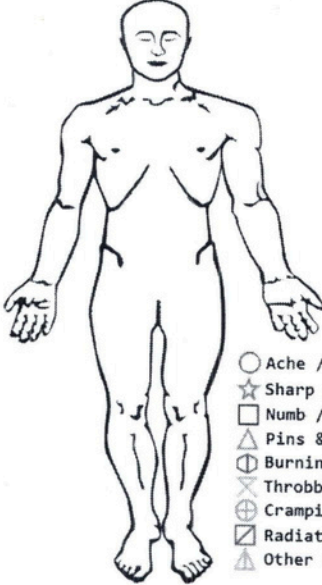
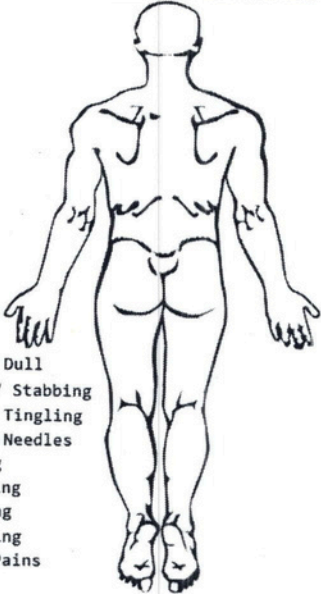


**\*\*PLEASE NOTE, THIS FORM CANNOT BE SUBMITTED BY A MOBILE DEVICE OR TABLET\*\***

**Patient Information:**

Date	_____	SSN	_____	Birthday	_____
First Name	_____	Middle Name	_____	Last Name	_____
Sex	<input type="radio"/> Male <input type="radio"/> Female	Height	_____	Weight	_____
Married/Civil Union:	_____	Spouse Name	_____	# of Children	_____
Home #	_____	Cell #	_____	Work #	_____
Address	_____				
City	_____	State	_____	Zip	_____
Emergency Contact	_____	Emergency Relation	_____	Emergency Phone	_____
Email	_____				

**Patient Symptoms:**

- Ache / Dull
- Sharp / Stabbing
- Numb / Tingling
- Pins & Needles
- Burning
- Throbbing
- Cramping
- Radiating
- Other Pains

# Wellness Project Chiropractic

## Reason for this Visit:

Describe the reason for this visit?

Please briefly describe, including the impact it has had on your life.

Wellness  Sports  Auto  Fall  Home Injury  Job  Chronic Discomfort  Other

Briefly Explain: \_\_\_\_\_

When did this concern begin? \_\_\_\_\_

Has this concern:  Gotten Worse  Stayed Constant  Come and Gone

Does this concern interfere with:  Work  Sleep  Daily Routine  Other Activities

Briefly Explain: \_\_\_\_\_

Has this concern occurred before?  Yes  No

Briefly Explain: \_\_\_\_\_

Have you seen other doctor's for this concern?  Yes  No

Doctor's name: \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

Results:  Good  Bad  Indifferent

## Complaint Information:

Injury Occurred:  Work  Automobile  Third-Party  Other

Injury Date: \_\_\_\_\_

Injury Origin: \_\_\_\_\_

Desc Discomfort: \_\_\_\_\_

Interfere w/ Activities:  Yes  No Affected Sleep:  Yes  No

Frequency: \_\_\_\_\_

Missed Work:  Yes  No Unable to Work from: \_\_\_\_\_

Unable to Work Until: \_\_\_\_\_

Affected Appetite:  Yes  No Explain: \_\_\_\_\_

Reduced Work:  Yes  No Explain: \_\_\_\_\_

Does it Worsen:  Yes  No Explain: \_\_\_\_\_

Weather Affects it:  Yes  No Explain: \_\_\_\_\_

Aggravates Condition: \_\_\_\_\_

Improves Condition: \_\_\_\_\_

Received Treatment:  Yes  No Explain: \_\_\_\_\_

X-rays Taken:  Yes  No Explain: \_\_\_\_\_

Pain level Rating - Scale 1 to 10: At its best: \_\_\_\_\_ At its Worst: \_\_\_\_\_ Current Level: \_\_\_\_\_

Same Condition Before:  Yes  No Date: \_\_\_\_\_ Practitioner: \_\_\_\_\_

## For Women Only:

Are you pregnant?  Yes  No

Are you taking birth control?  Yes  No

Do you take HRT?  Yes  No

Are you nursing?  Yes  No

Do you experience painful periods?  Yes  No

Do you have irregular cycles?  Yes  No

Do you perform a regular self breast examination?  Yes  No

Do you have breast implants?  Yes  No

Do you take oral contraceptives?  Yes  No

Date of last PAP/pelvic exam? \_\_\_\_\_ Date of last mammogram? \_\_\_\_\_

Date of Last Menstrual Period? \_\_\_\_\_

**Health Checklist:**

- Alcoholism
- Arteriosclerosis
- Autoimmune Disease
- Breast Lump
- Cancer
- CHF
- COPD/emphysema
- Dementia/Alzheimer's
- Diagnosed emotional/mental
- Epilepsy
- Fatigue
- Glaucoma
- Hemorrhoids
- Irregular Heart Beat
- Kidney Stones
- Loss of Memory
- Lung disease
- Nosebleeds
- Polio
- Retinal Disease
- Shortness of Breath
- Sleep Problems/Insomnia
- Stroke
- Thyroid Condition
- Varicose Veins

- Allergies
- Arthritis
- Back Pain
- Bronchitis
- Cataracts
- Cold Extremities
- Cramps
- Depression
- Digestion Problems
- Excessive Menstruation
- Frequent Urination
- Gout
- High Blood Pressure
- Irregular Menstrual Cycle
- Liver disease/cirrhosis
- Loss of Smell
- Macular Degeneration
- Pacemaker
- Poor Posture
- Sciatica
- Sinus Infection
- Smoked
- Swelling of Ankles
- Tuberculosis
- Venereal Disease

- Anemia
- Asthma
- Bleeding Disorders
- Bruise Easily
- Chest Pain
- Constipation
- CVA (stroke/TIA)
- Diabetes
- Dizziness
- Eye Pain or Difficulties
- Gallbladder disease/stones
- Headache
- Hot Flashes
- Kidney Infection
- Loss of Balance
- Loss of Taste
- Migraines
- Parkinson's
- Prostate Trouble
- Seizures
- Skin Sensitivity
- Spinal Curvatures
- Swollen Joints
- Ulcers
- Other

Have you had any of these Cardiovascular Diseases? Please select all that apply.

- Myocardial infarction
- Hypertension
- Bypass surgery
- Coronary artery disease
- Hypercholesterolemia

Do you have Diabetes? If so what type?

- Type I    Type II    Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

- Ulcers
- Reflux
- IBS

### Personal Health History

Last Physical Exam:	_____	Primary Phys:	_____	Phys Phone #:	_____
Phys City:	_____	Phys State:	_____	Phys Zip:	_____
Health Conditions:	_____				
Previous Chiro Care:	<input type="radio"/> Yes <input type="radio"/> No	Date:	_____	Condition(s) treated:	_____
Chance Pregnant:	<input type="radio"/> Yes <input type="radio"/> No	Planning:	<input type="radio"/> Yes <input type="radio"/> No		
Medications:	_____				
Supplements:	_____				

### Personal Incident History:

Broken Bones:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain	_____
Sprains/Strains:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain	_____
Hospitalized:	<input type="radio"/> Yes <input type="radio"/> No	Explain:	_____		
Surgery:	<input type="radio"/> Yes <input type="radio"/> No	Explain:	_____		
Auto Accident:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain	_____
Struck Unconscious:	<input type="radio"/> Yes <input type="radio"/> No	Treatment:	<input type="radio"/> Yes <input type="radio"/> No	Explain	_____
Eating Disorder:	<input type="radio"/> Yes <input type="radio"/> No	Explain:	_____		
Stroke:	<input type="radio"/> Yes <input type="radio"/> No	Explain:	_____		

**Family Health History:**

Family Health History

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature \_\_\_\_\_

Date: \_\_\_\_\_

## Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Wellness Project Chiropractic

3121 Washington Blvd., Marina Del Rey, CA 90292  
Phone: (310) 266-2980

Chiropractic Health Care  
Massage Therapy  
Acupuncture

drjapngiedc@gmail.com

## PRIVACY NOTICE AND PRACTICE REQUIREMENTS

**THE PRACTICE:**

- (a) Is a requirement by federal law to maintain the privacy of your Protected Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- (b) Under the Privacy Rule, we may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

**EFFECTIVE DATE:** This notice is in effect as of 04/15/2003

**PATIENT ACKNOWLEDGEMENT:** By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

PATIENT/GUARDIAN SIGNATURE:

DATE:

## CLINIC POLICIES

**1. CANCELLATION** - KINDLY GIVE US 24 HOURS NOTICE OF CANCELLATION FOR ALL APPOINTMENTS. IF NO ARRANGEMENTS HAVE BEEN MADE TO CANCEL YOUR APPOINTMENT, PLEASE NOTE THAT A **\$25.00 CANCELLATION FEE** WILL BE APPLIED TO YOUR ACCOUNT.

**2. COMMUNICATION** - Please communicate any physical problem areas to the massage therapist before starting the massage session as well as letting him or her know if there is too little or too much pressure or any discomfort during the massage so he or she can accommodate you.

**3. SEXUAL INUENDOS** - Verbal and physical innuendos are NOT TOLERATED. If reported, we will ask the individual to leave the premises.

**4. MASSAGE TIMES** - Half-hour massages are 20 minutes in length, Hour massages are 50 minutes in length and Hour and a half massages are 80 minutes in length. This will allow adequate time for individuals to undress/dress and for the therapist to prepare their rooms.

Thank you for your your cooperation and understanding regarding these policies.

PATIENT/GUARDIAN SIGNATURE:

DATE:

WITNESS (FOR OFFICE USE ONLY)

DATE:

# Wellness Project Chiropractic

3121 Washington Blvd., Marina Del Rey, CA 90292

Phone: (310) 266-2980

Chiropractic Health Care  
Massage Therapy  
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drjapngiedc@gmail.com

## INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD AND IDENTIFICATION TO THE FRONT DESK)

### ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I understand that I am financially responsible for any balance and authorize my insurance benefits be paid directly to the physician. I hereby direct my insurance company to pay by check made out and mailed directly to:

**Dr. Luis Albert JapNgie, DC**  
**3121 Washington Blvd.**  
**Marina Del Rey, CA 90292**

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows to:

**WELNESS PROJECT CHIROPRACTIC**  
**3121 Washington Blvd.**  
**Marina Del Rey, CA 90292**

For the professional or medical expense benefits allowable, and otherwise payable to me, under my current insurance policy as payment toward the total charges for professional services rendered.

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS & BENEFITS UNDER THIS POLICY.**

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand the above doctor has a financial interest in any diagnostic testing.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

SIGNATURE OF POLICY HOLDER:

DATE:

SIGNATURE OF CLAIMANT: (if other than Policy Holder)

DATE: