



We are excited to be able to offer you the convenience of filling out our intake form online. Please answer every question so we can provide you the best possible care. Once completed, email us the paperwork to monica@slowellness.com

S E C T I O N 1

Today's date: ____/____/____ file #: _____

Name: _____

What do you prefer to be called?: _____

Male ___ Female ___ Birth Date: ____/____/____ Age: _____ SSN#: _____ - _____ - _____

Mailing address: _____
City State Zip

How would you like to receive your appointment reminder in the future (please circle one) Email Text Phone call

If you'd like to receive a text, please let us know your provider (Verizon, Att, etc.):

Email address: _____

Home phone #: _____ Cell Phone #: _____

Whom may we thank for referring you?: _____

Who is your employer?: _____

Employer's address: _____
City State Zip

Occupation: _____ Work #: _____

Marital Status: (Please highlight one) Single Married Divorced Separated Widowed Domestic Partner

Children: Number of children

S E C T I O N 2

(Please read carefully and initial)

SLO Wellness Center (SWC) is a partnership between Sachs Chiropractic Inc. and Stevens Chiropractic Inc. SWC invites you to discuss with us any questions regarding your care and our services. The best health care is based on a friendly, mutual understanding between provider and patient.

SWC requests payment in full for all services at the time of visit, unless other arrangements have been made.

____ I understand that SWC can bill my insurance as a courtesy and I am ultimately responsible for payment of services provided.

____ I hereby authorize SWC and whomever they designate to administer treatment, as they so deem necessary. I also authorize the provider(s) and / or managed care organization to release my information to provide other health care providers with information related to my care as well as to process insurance claims.

____ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by __Rex Stevens, D.C. __Molly Stevens, D.C. __Sandy Sachs, D.C __Miro Bandalo, D.C.

____ 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 authorize the treating doctor to provide the necessary treatment that is within the scope and common practice of the chiropractic license in the State of California.

____ I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment from my present condition(s) and for any future condition(s) for which I seek treatment in this office.

Signature: _____ Date: _____

We look forward to being YOUR resource for chiropractic care on the central coast

- Drs. Rex and Molly Stevens, Dr. Sandy Sachs, Dr. Miro Bandalo

S E C T I O N 3

Name: _____

Please explain the primary reason for visiting our office:
1. _____
2. _____
3. _____

When did your current condition begin? _____/_____/_____

Have you ever had this condition before? _____ If so, please describe: _____

Was this the result of an accident?

If yes, was it from auto work-related other _____

Would you describe the problem as getting better getting worse constant comes and goes?

Is the problem interfering with your work, sleep, daily routine? If so, please describe: _____

Have you sought any other treatment before this? _____ If so, please describe: _____

Have you ever been to a chiropractor before? _____ If so, whom? Name: _____

Where? _____ What did you enjoy most about their care? _____

What other forms of health care do you use? Acupuncture _____

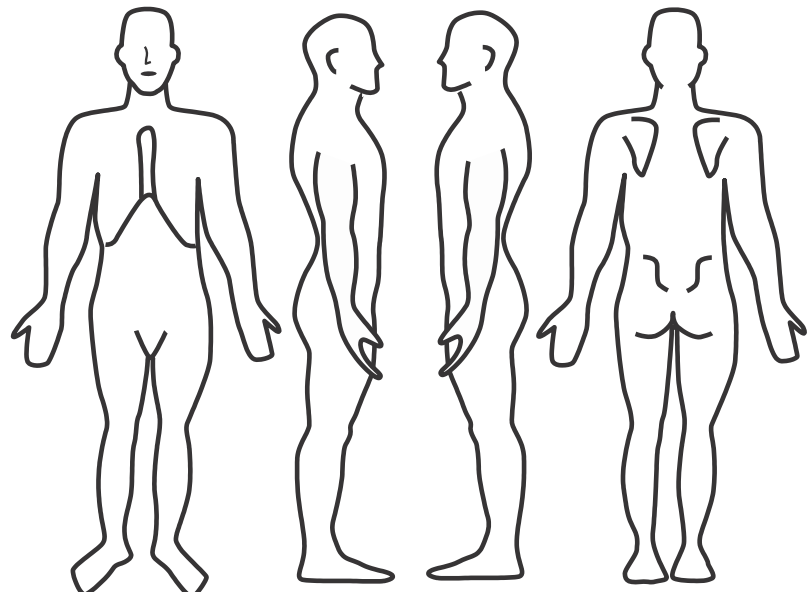
Massage _____

MD _____ name

Other _____

S E C T I O N 4

Please show me where you are experiencing pain and/or discomfort by putting an X or circling the body:



Front

Right

Left

Back

S E C T I O N 5

Name: _____

Please list any supplements you are taking, including vitamins, herbs, etc.?

- 1. _____
- 2. _____

Please list any medications you are taking, including over the counter meds?

- 1. _____
- 2. _____

Have you had any of the following condition(s) (delete those that don't pertain)?

Heart attack/stroke	Heart Surgery	Heart Murmur
Congenital Heart defect	Mitral Valve Prolapse	Rheumatic Fever
Hepatitis	Shingles	Emphysema/ Glaucoma
Artificial Valves	Arthritis (type) _____	Cancer (type) _____
Anemia	Kidney Problems	Ulcers/Colitis
Diabetes/Tuberculosis	Artificial Bones/Joints	Eye Disorders

Please list any other serious medical conditions you have or ever had:

Medical Conditions	Surgeries	Serious Accident/Trauma
1. _____	_____	_____
2. _____	_____	_____
3. _____	3. _____	_____

Please list anything you may be allergic to:

S E C T I O N 6

Health habits:

What do you do for physical activity? _____

What are your hobbies? _____

I eat **1 2 3 4 5 >5 (highlight one)** meals per day

My diet consists of (**highlight all that apply**): fruits, vegetables, chicken, beef, fast foods, sodas, caffeine

I drink approximately _____ cups of water/day

How much un-interrupted sleep do you get per night? _____

I sleep on my (**highlight all that apply**) back side (R/L) stomach

My pillow is (**highlight one**) too hard too soft just right

How old is your mattress? _____ Is it comfortable? _____

Would you be interested in additional information regarding:

- 1. Therapeutic Pillows
- 2. Vitamin Supplementation
- 3. Orthotics/foot supports

Do you smoke? _____ How much? _____ For how long? _____

Name: _____

Please answer Y if you experience or have experienced:

Past Present

<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Smell
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Balance
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Sore Throat
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Scalp Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Poor Memory
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Rate
<input type="checkbox"/>	<input type="checkbox"/>	Depression

Past Present

<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Head
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw/TMJ
<input type="checkbox"/>	<input type="checkbox"/>	Neck Soreness
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Tension
<input type="checkbox"/>	<input type="checkbox"/>	Arm Pain
<input type="checkbox"/>	<input type="checkbox"/>	Tennis Elbow
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Arm Power
<input type="checkbox"/>	<input type="checkbox"/>	Pins & Needles in Hands
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Grip

Past Present

<input type="checkbox"/>	<input type="checkbox"/>	Mid-back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Mid-back Tension
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ribs
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain/Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Buttock Pain
<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain
<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps
<input type="checkbox"/>	<input type="checkbox"/>	Pins & needles in Legs
<input type="checkbox"/>	<input type="checkbox"/>	Knee Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Foot Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Pins & needles in Feet
<input type="checkbox"/>	<input type="checkbox"/>	Ankle Pain

For women: Are you taking birth control? Are you pregnant?

Are you nursing?

Are you experiencing menopausal symptoms?

If yes, please describe

Are you experiencing any breast soreness/lumps?