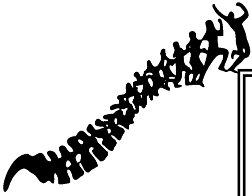

Olympic Chiropractic Welcomes YOU!

When a person seeks the services of a chiropractor, it is essential that they fully understand the objectives of that particular chiropractor.

We have one goal at Olympic Chiropractic; to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are located in and protected by the bones of the spine. Misalignments of the vertebrae (bones of the spine), which interfere with the function of these nerve pathways, are called vertebral subluxations. Subluxations are caused by many of the things you do everyday and keep your whole body from functioning properly. It is our absolute conviction that the body is always better off without this interference.

Consequently, the objective of Olympic Chiropractic is to provide a chiropractic adjustment to correct subluxations thereby restoring normal nerve function. It is not the objective or intention of this office to fix, treat or attempt to cure any physical, mental or emotional ailment or to give advice about any ailments. With a proper nerve supply your whole body is better able to reach its full potential and to express more life.

The information we receive from you is important. We ask only that which is necessary for your care here. Please fill out the forms completely and to the best of you ability. If you have any questions or if there is any information you feel we should know, please let us know.

I, (we) ____, have read the above, understand it fully and choose to receive chiropractic for myself and for my family members listed below.

____

____

____

____

____

____________________________________ ____________________

Signature **Date**

PATIENT INFORMATION SHEET

Last Name___________________First Name__________________Middle___________

Gender M F Date of Birth___/___/___ Age_____ S S #_______________________

Home Address____

City__________________________________State___________________Zip________

Home Phone #__________________________Work Phone #______________________

Cell #____________________ Email____

Employer Name____________________________Occupation____________________

Employer Address____

City__________________________________State___________________Zip________

Whom May We Thank For Referring You To Our Office?____________________

SPOUSE or GUARDIAN:

Last Name___________________First Name_________________Middle____________

Employer Name____

Work Phone #____________________Date of Birth___/___/___ S S #_______________

EMERGENCY: Name and address of nearest relative or friend not living with you

Last Name___________________First Name________________Relationship_________

Home Phone#________________________Work Phone#_________________________

PAYMENT METHOD: ( )CASH ( )CHECK ( )CREDIT CARD

INSURANCE COMPANY:______________________ I.D.#_____________________________

RESPONSIBLE PARTY:_____________________________RELATIONSHIP:_____________

SIGNATURE: (Parent, Patient, Legal Guardian or Responsible Party)

I request services. X______________________________________

ABOUT YOU

What are your goals with today's visit?____

____

Number of children: ____________

Children's names and ages:

____

____

____

Hobbies and Interests:

____

____

____

Have you been to a chiropractor before? Y__N___

Who and when___________________________

Have you seen an MD within the last year? Y____ N____ If yes, please explain:____

____

What brings you to the office today?

____

____

____

If you have no specific problem but are here to have your spine checked for vertebral subluxation, check here: ____

List any surgeries, falls, accidents or injuries, including complications during or after your own birth

____

____

____

WOMEN: Is there a possibility you are pregnant? Y____ N____

Current Medications:____

Vitamins:____

Last time you saw the dentist?__________________Optometrist?________________________

What exercises do you perform?____Frequency________

Was your birth: c-section_____vacume_____forceps_____

Were you vaccinated:_____Y_____N Breast-fed:_____Y_____N Abused:_____Y_____N

How old is your mattress?_________________ Do you use green cleaning products? Y__N__

Do you smoke?______ Drink?_______ Use drugs?______

Please Mark C=Current, P=Past, F=Family next to the following conditions

Alcoholism	**Convulsions**	**Heart Attack**	**Miscarriage**
Allergy	**Depression**	**Heart Disease**	**Neck Pain**
Anemia	**Diarrhea**	**High Blood Pressure**	**Polio**
Arthritis	**Diabetes**	**Hypoglycemia**	**Sinus Trouble**
Back Aches	**Epilepsy**	**Measles**	**Stroke**
Cancer	**Gall Bladder**	**Menstrual Irregularity**	**Ulcers**
Cold Sores	**Gout**	**Migraine**	**Constipation**
Vascular Disease	**Multiple Sclerosis**	**Headaches**	**Difficulty with Sleep**

Other:____
____

What do you do for fun?____

How are your activities hampered by your present health status if any?____

What activities do you envision doing when you retire?____

Who would you like to be doing these activities with?______________________

ON A SCALE OF 1-10:
How committed are you to maximizing your health potential? ______
How committed are you to maximizing the health potential of your family?______
What if any spinal maintenance programs have you been given in the past?____
Did you follow them?__________

PAYMENT POLICIES

1. PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.
2. SIGNATURE BELOW ACKNOWLEDGES THAT IF YOUR PERSONAL BALANCE EXCEEDS $250.00, YOUR CREDIT CARD (LISTED BELOW) WILL AUTOMATICALLY BE CHARGED THE FULL AMOUNT DUE. _______initial

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ASSIGNMENT & RELEASE

I authorize release of information to family, physicians, employer and insurance companies.
I authorize the taking of photographs and x-rays to be used for treatment purposes.
I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.
I authorize my insurance benefits (if any) to be paid directly to:

OLYMPIC CHIROPRACTIC/DR. GLENN FISCHEL
11545 Olympic Blvd.
Los Angeles, CA 90064

I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care any fees for professional services rendered me will be **immediately** due and payable.

Patient's Signature:____Date:________

Guardian's Signature:____Date:__________

Bank:____________________Branch:____________________

AMEX VISA DISCOVER M/C

Credit Card#:______________________________Exp:________VCODE:______Billing Zip:_______