CASE HISTORY

Patient History

Name_____ Date_____

Address_____City_____State_____ Zip_____

Email Address _____Cell #(_____)_____

Work # (_____)_____Home #(_____)_____ Date of Birth_____ Age_____

Referred by_____Social Security #_____

Occupation_____Employer_____

Marital Status S M D W Spouse Name_____ Have you ever received Chiropractic Care? Yes No

If yes please explain

Current Health Habits:

Did/do you smoke?	Y N	_____
Did/do you drink alcohol?	Y N	_____
Diet, do you eat healthy foods?	Y N	_____
Have you been in accidents/trauma?	Y N	_____
Have you had surgery?	Y N	_____
Drugs, prescription, OTC, recreational?	Y N	_____
Dental problems?	Y N	_____
Eye problems?	Y N	_____
Hearing problems?	Y N	_____
Exercise regularly?	Y N	_____
Did/do you have occupational stress?	Y N	_____
Drive? Daily time spent driving	Y N	_____
Physical stress?	Y N	_____
Emotional/Mental stress?	Y N	_____
Hobbies/Sports injuries?	Y N	_____
Do you sleep well, hours of sleep?	Y N	_____
Sleeping posture? O side O stomach O back		_____

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:

Major_____

Pain or Problem started on_____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____

Does this pain shoot, radiate, or travel in your body? Where?_____

Are you experiencing numbness or tingling in any area of your body? Where?_____

Since it began, is it: O Same O Better O Worst

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is this condition worse during certain times of the day?_____

Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____

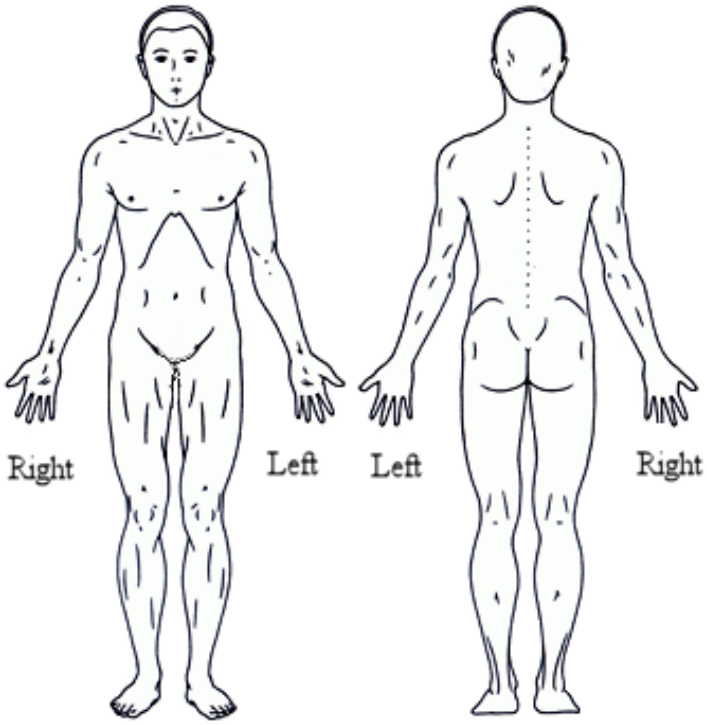
Is this condition progressively getting worse?_____

Other Doctors seen for this condition_____

Any home remedies? _____

Using the symbol below,
mark on the pictures where you feel pain.

Please Circle where you are at: (No Complaint / Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)



Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:

Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for any condition?_____

What Medications are you taking?_____

How long?_____ Have you had surgery?_____ What?_____ When?_____

What side effects have you experienced from the drugs and surgery?_____

Females Only – Date last Menstrual Period began on_____ Are you possibly Pregnant?_____

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____

*Waiver and Assumption of Risk

*I, _____, Customer, of Crush It Marketing Inc., City of Carson, State of California , voluntarily sign this waiver and assumption of risk in favor of Steven Sanchez, Owner, of West Coast Sports & Fitness Center City of Carson, State of California , in consideration for the opportunity to use the owner's facilities and/or the opportunity to receive instruction from the owner or the owner's employees, independent contractors and/or to engage in the activities sponsored by the owner.

*I understand that there are certain risks and dangers associated with the activity and use of the facilities and that these risks have been fully explained to me. I fully understand the danger involved. I fully assume the risks involved as acceptable to me and I agree to use my best judgment in undertaking these activities and follow all safety instructions. I waive and release the owner, owner's employees and independent contractors from any claim for personal injury, property damage, or death that may arise from my use of the facilities or from my participation in the activities or instruction.

IF CHILDREN ARE BROUGHT IN WITH PARENTS DURING EXERCISE SESSION PARENTS WILL TAKE FULL RESPONSIBILITY OF CHILD WHILE AT WEST COAST SPORTS & FITNESS CENTER. I RELEASE, DISCHARGE, WAIVE AND COVENENT NOT TO SUE CRUSH IT MARKETING INC, AND ALL THEIR RESPECTIVE AGENTS IF AN INCIDENT OCCURS FOR ANY REASON . I AS A PARENT TAKE FULL RESPONSIBILITY

*I have carefully read this Waiver and Release and fully understand its contents. My parent or legal guardian has completely reviewed this Waiver and Release, understands and consents to its terms, and authorizes my participation by his/her signature below. I am aware that this is a RELEASE OF LIABILITY and a contract between me and the persons and entities mentioned above and I sign of my own free will.
**Photographic Release* : Digital photographs and video are taken of many West Coast Sports & Fitness Center Athletes & Fitness Clients. I hereby give WCSF Center permission to use such photographs and/or video for public displays, training material and/or media releases. I understand these photographs and/or video images will be for news, training and/or Information purposes only.

- Instructors are in charge at all times.
- Participation is allowed only when following the guidelines of the instructors, and always under their supervision.
- Sign-in is required of all participants (even those with an Open Gym waiver on file)
- Only WCSF Center Instructors may assist participants with activities
- No horseplay, rough housing, running, pushing, misuse of equipment, or dangerous activities will be tolerated.
- No food or drink is allowed on the gym floor at any time! Please enjoy drinks and snacks in our lobby area.

*If you feel that there is **ANY** health reason why you should not participate in physical activity, check with your doctor before beginning this program. Provision to this agreement is governed by California law and any disputes shall be resolved in Carson, California

Participant Signature:_____

Print Name:_____ Date:_____

Parent/Guardian Signature:_____

Print Name:_____ Date:_____

PATIENT NAME:

ARBITRATION 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 state and federal law, and not by 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.

Article 2: 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 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 office whether signatories 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 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 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 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 state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. 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 the 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 the date of 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 PRACTICE 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 X (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE X (Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist 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 understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.
By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

PATIENT SIGNATURE X (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE