Southern California Health Center
Chiropractic / Acupuncture / Sports Medicine

Medical History Form

Name: _____ Date_____

Address_____Date of Birth: _____

City_____State_____Zip_____SS/MedicareNumber:_____

Home Phone: _____ Cell Phone: _____Work Phone:_____

Email:_____

Gender: M F Married: Y N Spouse's Name_____

How did you hear from us? Google □ Groupon □ Living Social □ Friend □

Doctor Referral □ _____ Other □ _____

Emergency Contact: Name_____ Phone Number: _____

Address_____City_____State___

Zip_____

Medical Doctor Name: _____ Phone: _____

Main Problem

What causes you to come into our office today?_____

_____

Do you know what caused this problem?_____

_____

When did this problem start?_____ How long does the pain/problem last?_____

How bad is the problem and/or pain? (Circle the one that applies)

Mild Moderate Severe Intolerable

Circle the word or words that best describe any pain.

Cramping Aching Dull Deep Sharp
Shooting Throbbing Nagging Burning Pressure like

How often does the problem and/or pain occur? (Circle the one that applies)

Occasional Frequent Constant

Does this problem and/or pain travel to any other area?

_____

What makes the problem/pain better? _____

What makes the problem/pain worse? _____

Are you interested in Chiropractic Care _____, Acupuncture _____, Both _____.

What else have you done to treat this

problem/pain?_____

_____

Minor Problem

What other problem/pain do you have? _____

_____

What caused this problem/pain?_____

_____

When did this problem/pain start?_____

How long does this problem/pain last?_____

How bad is the problem and/or pain? (Circle the one that applies)

Mild Moderate Severe Intolerable

Circle the word or words that best describe the pain.

Cramping Aching Dull Deep Sharp

Shooting Throbbing Nagging Burning Pressure like

How often does the problem/pain occur? (Circle the one that applies)

Occasional Frequent Constant

Does this problem/pain travel to any other area? _____

What makes the problem/pain better? _____

What makes the problem/pain worse? _____

What else have you done to treat this problem/pain?_____

Additional Questions:

Have you ever been hospitalized?_____

Have you ever had surgery?_____

Do you have any known allergies?_____

Did you know? Research has shown that chiropractic and/or acupuncture can help with the following conditions,

Please check all that apply to you:

Addiction (caffeine, nicotine, alcohol, etc.) _____
Anxiety _____
Arthritis _____
Asthma _____
Carpal Tunnel Syndrome _____
Chronic fatigue _____
Constipation _____
Dental Pain _____
Depression _____
Diarrhea _____
Digestive trouble _____
Dizziness _____
Emotional problems (mood swings, etc.) _____
Eye problems _____
Fatigue _____
Fertility _____
Fibromyalgia _____
Headache _____
Hiccough _____
Indigestion _____
Irritable bowel syndrome _____
Low back pain _____
Menopause _____
Menstrual Irregularities _____
Migraine _____
Morning sickness _____
Nausea _____
Nerve Pain _____
Osteoarthritis _____
PMS _____
Reproductive problems ____
Sciatica ____
Seasonal Allergies_____
Shoulder Pain _____
Sinusitis _____
Sleep disturbances _____
Smoking cessation _____
Sore throat _____
Stress _____
Tennis elbow _____
Tonsilitis _____
Tooth pain _____
Trigeminal neuralgia _____
Urinary tract infections _____
Vomiting _____
Wrist pain _____

CONSENT FOR EXAMINATION AND TREATMENT

I understand that Dr. Zubin Dah is an independent contracting doctor and is licensed in the state of California as a practicing chiropractor and acupuncturist. I am confirming that I may be examined and treated by the doctor in any way he sees fit for the treatment of my complaint and/or condition.

I understand that the doctor is a multidisciplinary doctor. I acknowledge that during the course of my care I (or the person named below for whom I am legally responsible) may receive chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, acupuncture and other oriental medicine procedures.

I understand that, as in the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments the most common risks are temporary aggravation of my condition or soreness. Rarer risks include, but are not limited to, fractures, strokes, dislocations, sprains, burns and aggravation of disc injuries.

I understand that if I receive acupuncture and oriental medicine treatments the risks include but are not limited to: minor bleeding, local bruising, fainting, temporary pain or discomfort and the possible temporary aggravation of prior existing symptoms. I also understand that allergic reactions to supplements, latex gloves or other substances may occur and will inform the doctor of any known allergy.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him or her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

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 for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's name (please print) Date

_____

Signature of patient (or guardian if patient is a minor)

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 California and federal law, and not by a 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 or 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 clinic or office whether signatories to 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 the 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 incurred 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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 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 of 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 MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

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

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

NCC-CA