Northern California
CHIROPRACTIC & SPORTS THERAPY

CASE HISTORY

Date: _____

Name: _____ Phone (Home): _____

Address: _____ Phone (Work): _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Email: _____

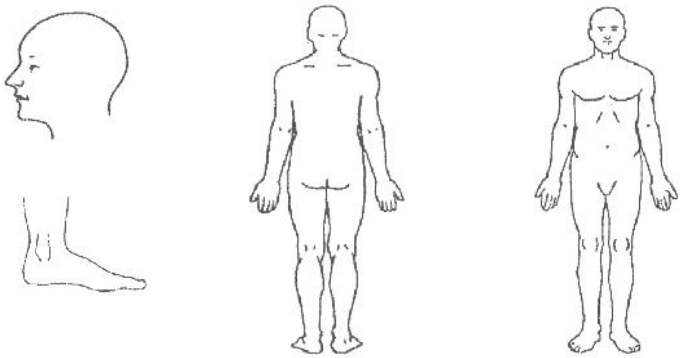
Social Security Number: _____ Doctor's Name: _____

Chief Complaint / List Current Problems

1. _____ Duration (How Long): _____ Previous Episodes: _____
2. _____ Duration (How Long): _____ Previous Episodes: _____
3. _____ Duration (How Long): _____ Previous Episodes: _____

Please mark area and type of pain on the drawings using the codes listed below.

Pain = **P** Numbness = **N**
Stiffness = **ST** Tingling = **T**
Ache = **A** Soreness = **S**



Prior operations and procedures: _____

List any accidents or falls and dates: ☐ Car: _____ ☐ Recreation Vehicle: _____

☐ Sports: _____ ☐School: _____ ☐ Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ☐ Yes ☐ No Why? _____

Have you ever had any spinal taps or spinal injections? ☐ Yes ☐ No Were you ever knocked unconscious? ☐ Yes ☐ No

Have you ever had a lapse of memory? ☐ Yes ☐ No

Have you ever had X-rays taken? ☐ Yes ☐ No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication – prescription or over the counter? ☐ No ☐ Yes What drugs? _____

_____

What are your goals or expectations for your treatment (e.g. decreased pain, increased function, etc.)? _____

_____

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I HAVE READ AND UNDERSTAND THE ABOVE

Patient's/Guardian's Signature: _____ Date: _____

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INFORMED CONSENT OF A MINOR CHILD

I hereby request and consent to the performance of sports therapy treatment and any other sports therapy procedures, including examination test, physiotherapy, and soft tissue therapy techniques, for me (or the patient named below for which I am legally responsible) which are recommended by the physician named below and/or other licensed physicians who now or in the future render treatment to me while employed by, associated with, or serving as back-up for the physician named below.

I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

I, being the parent or legal guardian, hereby authorize Dr. Timothy P. Angelo

and whomever he/she may designate as assistants to administer treatment as deemed necessary to

_____
Name of Minor

Dated at _____ this _____ day of _____, _____

Timothy P. Angelo, D.C. C.C.E.P.
Northern California Chiropractic & Sports Therapy
903 Embarcadero Drive, Suite 3
El Dorado Hills, CA 95762
P: (916) 933-9870 • F: (916) 933-3540

_____ _____
Signature of Parent or Legal Guardian **Date**

_____ _____
Printed Name of Parent or Legal Guardian (and relationship) **Date**

_____ _____
Authorized Facility Signature **Date**

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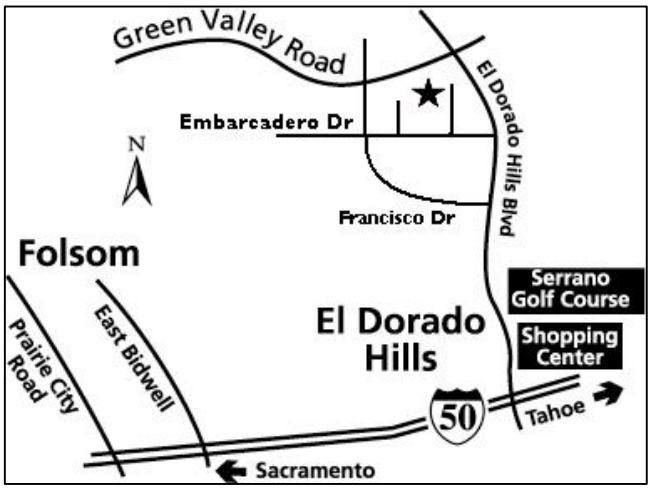
Fax: 916.933.3540

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