A Body Center

614-A Westminster Ave

Venice, CA 90291

310-985-1515

Dr. Douglas Stockel, D

INFORMED CONSENT FOR CHIROPRACTIC TREAMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including but not limited to various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for who I am legally responsible) by the doctors of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for or in consultation with the doctors of chiropractic named above, including those working at the clinic or office listed above or any other office, hospital, clinic or location.

I have had an opportunity to discuss with the doctor(s) of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

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, disk injuries, strokes, dislocations and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure which the doctor(s) feel at the time, based upon facts then known, is in by best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and 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.

TO BE COMPLETED BY PATIENT

Patient's name____Signature of Patient____
PLEASE PRINT

Date signed_________________________Witness to Patient's signature____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's name____Name of Representative____
PLEASE PRINT PLEASE PRINT

Date signed_________________________Signature of Representative____

Relationship or Authority of Patient's Representative____

DIAGNOSTIC TESTS AND OR X-RAY WAIVER

Patient's name____

This written letter will confirm that diagnostic tests and/or x-rays have been recommended to me by my doctor(s) of chiropractic. Nevertheless, I not to have these tests performed and therefore I do release and forever discharge Bryant Koh, D.C. and Yvoune Kara Petrie, D.C. from any responsibility of liability relating to any injury that may arise out of my present condition or health involvement, since my doctor will be unable to properly analyze my problem and care for it wi benefit of these tests. I further wish to attest to the fact that this Waiver is given voluntarily, and I understand by signing this form, I am waiving certain rights which I might have had in the event that my problem(s) is not corrected or stabilized. Nevertheless, I choose this Waiver knowing that my health may be jeopar due to my decision.

Date signed_________________________Signature____

Dr. Douglas Stockel, D

A Body Center

614 Westminster Ave
Venice, CA 90291
310-985-1515

HEALTH HISTORY SURVEY

PATIENT'S NAME____ DATE____________________

This will be part of your confidential health record. Mark the box next to any health problems you have had in the past 2 year:

GENERAL

	☐ nervousness	☐ anemia	☐ seizures	☐ thyroid disease
☐ depression	☐ chills	☐ cancer	☐ phobias	☐ weight loss or gain
☐ fevers	☐ fatigue	☐ bleeding	☐ fainting	☐ alcoholism/drug abuses
☐ night sweats	☐ diabetes	☐ dizziness	☐ headache	

GASTROINTESTINAL

☐ belching/gas	☐ hernia	☐ pain in abdomen	☐ bloody stools	☐ difficulty swallowing
☐ heartburn	☐ nausea	☐ vomiting blood	☐ constipation	☐ other_____________
☐ vomiting	☐ diarrhea	☐ liver problems	☐ hemorrhoids	

RESPIRATORY

☐ breathing problems	☐ chronic cough	☐ asthma	☐ pneumonia
☐ spitting phlegm/blood	☐ shortness of breath	☐ allergies	☐ other_______________

CARDIOVASCULAR

	☐ heart pain	☐ prior heart problem	☐ stroke
☐ swelling	☐ irregular heartbeat	☐ high blood pressure	☐ other____________________

MUSCULOSKELETAL

☐ stiffness	☐ twitching	☐ pain	☐ weakness	☐ arthritis
☐ swelling	☐ spinal curve	☐ tremor	☐ numbness/tingling	☐ other_____________

SKIN

	☐ rash	☐ redness	☐ scars	☐ other_____________
☐ itching	☐ moles	☐ hair changes		

EARS, EYES, NOSE AND THROAT

☐ poor vision	☐ throat problems	☐ eye pain	☐ dental problems	☐ nosebleeds
☐ double vision	☐ hearing problems	☐ ears rings	☐ sinus problems	☐ other_____________________

Date of last eye exam________________________ Do you wear glasses or contact lenses?____________________

GENITOURINARY

	☐ blood in urine	☐ venereal infection	☐ difficult urination	
☐ frequent urination	☐ urinary infection	☐ painful urination	☐ urinate at night	☐ other____________

WOMEN ONLY

☐ painful periods	☐ excessive flow	☐ hot flashes	☐ breast pain	☐ difficulty becoming pregnant
☐ irregular cycles	☐ vaginal burning/itch	☐ lump in breast	☐ labor complications	☐ other_____________________

MEN ONLY

☐ testicular pain ☐ difficulty achieving errection ☐ prostate problems ☐ low sperm count

EXERCISE

☐ None ☐ 1-2 times a week ☐ 3-5 times a week ☐ 6-7 times a week kind of exercise__________________________

HABITS

smoke __________# packs/day caffeine __________# cups/day
alcohol__________# drinks/week recreational drug use________________________

FAMILY

Are your parents living?____________ Ages: mother_______father_______ Do you consider them in good health?__________________

Mark the box next to the information if it applies to your parents, grandparents, siblings or children.

☐ diabetes	☐ cancer	☐ seizures	☐ kidney disease	☐ lung disase	☐ high blood pressure
☐ stroke	☐ ulcers	☐ brain disorder	☐ heart disease	☐ arthritis	other_____________

›.C.

nout

rdied

.C.

s.