Welcome to Center for Healing Life

This document constitutes informed consent to treat for health care.
CA Code of Regulations, Title 16, Div. 4, Section 319.1

- On the days of your visits, the doctor will conduct various exams, which may include neurology (nerves), orthopedic (joints), Chiropractic (spinal), nutritional, neuro-emotional and kinesiological (muscle) exams. Based on the results of these exams, your health history and that of your family, clinical judgments will determine the types of treatment needs and if there should be a need for x-ray, lab analysis and/or referral to a specialist. In addition to specific spinal adjustments you may require nutritional counseling, exercise therapy and neuro-emotional support. Historically none of these constitute a risk of harm.
- When a person seeks health care at CFHL and we accept a client for health care, it is essential for both to be working towards the same goal: HEALTH BALANCE. We have only one goal. It is important for each patient to understand this goal and the methods that will be used to attain it. You need to comply and do your part in your return to health.
- Subluxations are mechanical interferences to the normal flow of mental impulses traveling over the nerve pathways. Our goal is to locate, analyze and correct these subluxations by specific adjustments of the body. These adjustments are intended to reduce nerve interferences thereby allowing the innate healing abilities of the body to work at maximum efficiency. With a proper nerve supply restored, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and recovery is complete; in others, only partially.

Should you experience discomfort inform us immediately or by phone or E-mail.

- We do not offer to diagnose or threat any disease or condition other than imbalances. However, if during the course of an examination, we encounter unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.
- Our office is on a private pay basis; payment is expected at the time services are rendered.

I,_____have heard and read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care

in this office have been answered to my complete satisfaction. I therefore give consent and accept care on that basis
signature_____date_____

For minor_____ I,_____, being the parent or legal guardian fully understand the above terms and grant permission for treatment. date_____

Khelly Webb, D.C. 562-433-7395

Khelly Webb, DC

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New Patient Intake Form

Welcome! Holistic health and preventive care are possible when the doctor has a complete understanding of your health history. Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential.

Personal Information

Name _____ Today's Date: ____/_____/_____

Female ___ Male __ Age _____ Date of birth _____/_____/_____

Phone: Home (_____)_____Work (_____)_____ Mobile (_____)_____

Preferred ___ Home ___ Work ___Mobile ___ Is it OK to leave messages? ___Yes ___No

Address_____ Apt # _____

City _____ State _____ Zip Code _____

Email address _____

Are you interested in receiving email newsletter? ___ Yes ___ No

If the patient is under the age of 18:

Name of mother _____ Phone number _____

Name of father_____ Phone number _____

Who may we thank for your referral? _____

When did you last receive health care? _____

Who? _____ Chiropractic? _____

What is your most important reason for making this appointment? _____

_____

Please list other health concerns, in order of importance: _____

_____

_____

Emergency Contact

Name _____

Relationship _____

Phone Number Day (_____)_____Evening (_____)_____

Address _____ Apt# _____

City _____ St _____ Zip Code _____

Health History

Please list any known allergies (environmental, drug, food): _____

_____

_____

Do you take any of the following over-the-counter medications? Please check any that apply:

___ Aspirin ___ Ibuprofen or acetaminophen ___ Antihistamine ___ Sleeping pills

___ Laxatives ___ Appetite depressants ___ Antacid ___ Medicine to stay awake

Please list ***medicines and supplements*** *that you are taking or have taken in the last year:*

Medication	Dosage	Dates	Reason for taking

If any of the following apply to you, please indicate dates:

Hospitalization Surgery when_____for _____

Surgery when_____for_____

X-ray ___where_____for_____

MRI ___ where_____for_____

Rectal exam ____when_____results_____

Electrocardiogram ___when_____results_____

Endoscopy ___
When _____ results_____

Colonoscopy __
When _____ results_____

Mammogram __
When _____ results_____

CT scan ____when_____results_____

Bone Scan___when_____results_____

Other _____

For the following conditions and symptoms, please indicate any that apply to you by marking
I/self, M/mother, F/father, S/sibling, C/child, O/other blood family

___ Skin rash
___ Anemia
___ Easy bleeding or bruising
___ Varicose veins or hemorrhoids
___ Bone or joint disease
___ Mood swings
___ Anxiety or nervousness
___ Difficulty sleeping
___ Feel unsafe at home
___ Physical abuse
___ Frequent antibiotic use
___ Frequent colds or flu
___ HIV or AIDS
___ Lyme disease
___ Rheumatic fever
___ Vaccinations
___ Cancer
___ Asthma, hay fever, rashes
___ High blood pressure
___ Alcoholism or substance abuse

___ Chronic pain
___ Fatigue
___ Weakness
___ Dizziness or fainting
___ Numbness / tingling / paralysis
___ Neurological disease
___ Seizures
___ Memory loss
___ Headaches
___ Head injury
___ Dental problems
___ Cold sores
___ Ear infections
___ Impaired hearing / vision
___ Sinus problems
___ Thyroid problems
___ Diabetes
___ Stroke
___ Depression
___ Autoimmune disease

___ Difficulty breathing
___ Chest pain
___ Heart palpitations
___ Atherosclerosis
___ Gastrointestinal disorder
___ Heartburn
___ Gastritis or ulcers
___ Excessive thirst / hunger
___ Hypoglycemia
___ Eating disorder
___ Parasites
___ Liver disease
___ Gallbladder disease
___ Kidney disease
___ Problems with urination
___ Sexual difficulties
___ Heart Disease
___ Osteoporosis
___ Attempted suicide
___ Other

When and where are your symptoms worse?

___ Morning ___ Afternoon ___ Evening ___ At home ___ Overnight ___ At work ___ No pattern ___ Upon waking ___ Other

Payment is due at the time of service; Cash or check.

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For Men Only

Please check all that apply to you:

___ Prostate exam _____ / _____ / _____
___ Regular self testicular exam
___ Impaired fertility
___ Sexual abuse
___ Heel Pain
___ Abnormal discharge from penis
___ Pain or lump in scrotum
___ Prostate problem
___ Sexually transmitted infection

For Women Only

Last menses _____ / _____ / _____
Last pap smear _____ / _____ / _____
Age menses began _____
Number of pregnancies _____
Number of live births _____

If you are still having periods:

Average number of days of bleeding _____
Average number of days in cycle _____
Bleeding is ___ Regular ___ Irregular
___ Light ___ Medium ___ Heavy
Symptoms ___ Bleeding btn periods ___ Mood swings
___ PMS ___ Painful menses ___ Breast tenderness

If you are no longer having periods:

___ Hot flashes ___ Vaginal dryness
___ Dry skin ___ Changes in memory
___ Spotting ___ Changes in libido
___ Facial hair ___ Changes in mood
___ Hair loss ___ Hormone replacement therapy
___ Incontinence ___ Urinary tract infections

Please check all that apply to you:

___ Hysterectomy _____ / _____ / _____
___ Abnormal pap smear
___ Breast pain / lump / nipple discharge
___ Sexual difficulties
___ Frequent vaginitis / chronic yeast infections
___ Abnormal vaginal discharge
___ Endometriosis
___ Polycystic ovary syndrome
___ Sexually transmitted infection
___ Pelvic inflammatory disease
___ Uterine fibroids
___ Impaired fertility
___ Sexual abuse
___ Regular self breast exam
___ Sexually active
___ Use methods to prevent pregnancy and/or sexually transmitted infections:
Current _____
Past _____

Lifestyle History

Please check any that apply to you and fill in corresponding details:

___ Exercise _____ hours per week
___Activities _____
___ Watch TV _____ hours per week
___ Tobacco use _____ packs per day
___ Alcohol use _____ drinks per week
___ Recreational drug use
___ Mercury amalgam fillings
___ Employed outside the home
Occupation _____
Hours per week _____
Employer _____
Do you enjoy your work? ___ Yes ___ No
Level of stress ___ Low ___ Average ___ High
___ Toxic exposure _____
___ Major life change in last year _____

Height _____
Weight _____
Weight one year ago _____
Maximum weight _____
When? _____
Sleep _____ hours per night
Is this enough? ___ Yes ___ No
Meals per day _____

The above information is true to the best of my knowledge.

_____ _____ / _____ / _____

Signature (Parent or guardian if patient is under 18 years old) *Date*

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