JAMES AYLOR, D.C.
HISTORY INTAKE FORM

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

ADDRESS (no PO boxes): _____ CITY: _____ STATE: _____ ZIP: _____

BIRTH DATE: _____ AGE: _____ SS#: _____ DRIVERS LICENSE #:_____

EMP/ADD: _____ OCCUPATION: _____

HOME PHONE: _____ WORK PHONE: _____ ALT PHONE: _____

NAME OF SPOUSE: _____ SPOUSE'S EMPLOYER: _____ OCCUPATION: _____

 # OF CHILDREN/AGES: _____

NAME OF EMERGENCY CONTACT: _____ PHONE: _____ RELATION: _____

INSURANCE: _____ POLICY ID#: _____

***EMAIL:* _____**

HOW WERE YOU REFERRED TO OUR OFFICE? _____

WHAT IS YOUR MAJOR COMPLAINT? _____

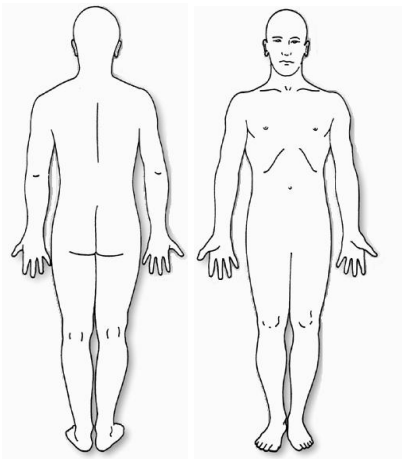
MARK AREAS WHERE YOU HAVE *PAIN/NUMBNESS* OR ARE CURRENTLY SUFFERING FROM: (PLEASE CHECK)

___ HEAD
___ NECK
___ UPPER BACK
___ MID BACK
___ LOWER BACK
___ SHOULDER
___ ARM
___ FOREARM
___ HAND
___ BUTTOCK
___ HIP
___ THIGH
___ LEG
___ FOOT
___ CANCER
___ GOUT
___ POLIO
___ ULCERS
___ LOSS OF FEELING
___ STIFF JOINTS
___ PAINFUL JOINTS
___ SORE MUSCLES
___ BROKEN BONES
___ MUSCLE CRAMPS
___ HEADACHES
___ DIZZINESS
___ FAINTING
___ ANEMIA
___ HEART TROUBLE
___ VISION PROBLEMS
___ EAR PAIN/NOISES
___ EAR INFECTIONS
___ CANKER SORES
___ HYPOGLYCEMIA
___ RHEUMATIC FEVER
___ VENEREAL DISEASE
___ HEARING LOSS
___ FREQUENT COLDS
___ ALLERGIES
___ HAY FEVER
___ ASTHMA
___ ECZEMA
___ SHINGLES
___ NAUSEA
___ POOR DIGESTION
___ SCOLIOSIS
___ DIARRHEA
___ CONSTIPATION
___ KIDNEY INFECTION
___ MENSTRUAL CRAMPS
___ EPILEPSY
___ PARKINSON'S DISEASE
___ RHEUMATOID ARTHRITIS
___ HIV/AIDS
___ DIABETES
___ BLOOD PRESSURE (HIGH/LOW)
___ TIREDNESS/FATIGUE
___ ANXIETY
___ PHOBIAS
___ DEPRESSION
___ SPINAL DISC DISEASE
___ MULTIPLE SCLEROSIS
___ PROSTATE TROUBLE
___ OSTEOARTHRITIS
___ ALCOHOLISM
___ GOITER
___ PNEUMONIA
___ SUICIDAL INTENT
___ OTHER
___
___
___

CURRENTLY YOUR PAIN IS AGGRAVATED BY:

___ COUGHING
___ SNEEZING
___ STRAINING AT STOOL
___ NECK MOVEMENT
___ REACHING
___ LIFTING
___ BENDING
___ SITTING
___ STANDING
___ WALKING
___ OTHER

PLEASE CIRCLE AREAS OF PAIN ON THE DIAGRAM …… →



CIRCLE YOUR PAIN

MILD MODERATE SEVERE
0…..…1…..…2…..…3…..…4…..…5…...6…..…7…..…8…..…9…..…10

HOW LONG HAVE YOU HAD THIS CONDITION? _____

HAVE YOU HAD THIS OR SIMILAR CONDITION IN THE PAST? _____

DID THIS ACCIDENT OCCUR WHILE AT WORK? ___ YES ___NO DATE OF INJURY: _____

HOW MANY DAYS A WEEK DO YOU HAVE THESE SYMPTOMS? _____

IS THIS CONDITION GETTING WORSE? ___ YES ___NO THE PAIN IS: ___CONSTANT ___COMES & GOES

IS THIS CONDITION INTERFERING WITH YOU WORK? ___YES ___NO

WHAT RELIEVES YOUR PROBLEM? ___ICE ___HEAT ___REST ___MUSCLE RELAXERS ___PHYSICAL THERAPY ___OTHER

- TURN OVER PLEASE -

(PLEASE CIRCLE APPROPRIATE RESPONSE) **THIS IS A NEW / OLD INJURY / ILLNESS. IT WAS / WAS NOT TREATED BEFORE.**

IF TREATED BEFORE, WHAT WAS DONE? _____

NAME OF DOCTOR: _____ DATE OF LAST VISIT: _____

LIST DATES OF ANY SURGERIES OR HOSPITALIZATIONS: _____

LAST TIME YOU HAD X-RAYS: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY ON: _____

(FROM BIRTH TO PRESENT) **LIST ANY CAR ACCIDENTS WITH DESCRIPTIONS AND DATES: _____**

_____

_____

_____

LIST FALLS/INJURIES: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am responsible for the payment. I understand I am responsible for deductibles and co-payments. I authorize JAMES AYLOR, D.C. to examine, take x-rays, and treat me in accordance with the state statutes for the care and management of my condition. I also understand that if I suspend care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____ Date: _____

I herby authorize the JAMES AYLOR, D.C. to administer treatment as necessary.

Guardian authorizing treatment: _____ Date: _____

Assignment & Instruction for direct payment to doctor for private and group accident/health insurance.

I hereby instruct and direct the _____ insurance company to pay by check, made out to Camarillo JAMES AYLOR, D.C. and mailed directly to: JAMES AYLOR, D.C., 1200 PASEO CAMARILLO STE. #160, CAMARILLO, CA 93010. If my current policy prohibits direct payments to doctor, then I hereby also instruct and dire you to make the check payable to me and mail it as follows: c/o JAMES AYLOR, D.C., 1200 PASEO CAMARILLO STE. #160, CAMARILLO, CA 93010. The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay in a current manner any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

SIGNATURE OF POLICYHOLDER: _____ DATE: _____

SIGNATURE OF CLAIMANT, IF OTHER THAN POLICYHOLDER: _____ DATE: _____

AUTHORIZATION TO RELEASE X-RAYS & MEDICAL INFORMATION

I _____ REQUEST THE FOLLOWING INFORMATION:

___RECORDS ___X-RAYS ___REPORTS ___OTHER

TO BE RELEASED TO: _____

FOR THE PURPOSE OF: ___REVIEW ___EVALUATION ___INSURANCE CLAIMS PROCESSING

___OR ANY PURPOSE REASONABLY RELATED TO THE ABOVE

I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON MY REQUEST. A PHOTOCOPY OF THIS RELEASE SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNED: _____

___PATIENT ___SPOUSE ___PARENT ___GUARDIAN

JAMES AYLOR, D.C., 1200 PASEO CAMARILLO STE. #160, CAMARILLO, CA 93010 (805) 987-1800