Dr. Nancy Doreo, DC CABNN DCN DCBN *Science Based Nutrition*
Professional Applied Kinesiology *Health Coach*

PERSONAL HISTORY

DATE: _____NAME:_____EMAIL_____

BIRTHDATE:_____AGE: _____ GENDER: M F X HEIGHT:_____WEIGHT: _____

ADDRESS:_____CSZ_____

PHONE (_____) _____ TYPE OF WORK: _____

CHECK ONE: ☐MARRIED/PARTNERED ☐SINGLE ☐WIDOWED ☐DIVORCED ☐SEPARATED

NUMBER OF CHILDREN: _____ AGES: _____

WHO IS RESPONSIBLE FOR YOUR BILL? YOU AND: SPOUSE OTHER:

NAME OTHER:_____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT: _____

_____

MAJOR COMPLAINT: _____

WHEN DID THIS CONDITION BEGIN: _____

WHERE WERE YOU WHEN THIS HAPPENED: _____

IF DISABLED FROM WORK, GIVE DATES: _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

MEDICATION YOU NOW TAKE: NERVE PILLS☐ PAIN KILLERS☐ MUSCLE RELAXERS☐ INSULIN☐
☐ALLERGY ASPIRIN☐ TYLENOL☐ IBUPROFEN☐ BLOOD PRESSURE☐ OTHER_____

VITAMINS/HERBS/REMEDIES:_____

PAST HEALTH HISTORY *PLEASE CHECK OR DESCRIBE:*

MAJOR SURGERY/OPERATIONS: ☐APPENDIX ☐TONSILS ☐GALL BLADDER ☐HERNIA
☐HEART ☐BACK ☐NECK ☐LEG ☐ORAL OTHER:_____

MAJOR ACCIDENTS/FALLS: _____

_____

OTHER HOSPITALIZATION: _____

PREVIOUS CHIROPRACTIC: LAST VISIT DATE _____DR'S NAME _____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION THIS LAST YEAR?

☐YES ☐NO IF YES, PLEASE EXPLAIN_____

Thousand Oaks, Ventura, Ojai
www.DrDoreo.com (805)777-7184 fax: (888)958-5491

WHY CHIROPRACTIC? People go to Chiropractors for a variety of reasons. Some go for relief of painful symptoms (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (CORRECTIVE CARE). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (COMPREHENSIVE CARE). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Comprehensive Care

☐ Please have the doctor select the best type of care for my condition.

_____ _____

Date Patient's Signature

If this is an accident-related injury, please ask for the Accident form.

THE PURPOSE OF OUR CHIROPRACTIC HEALTH AND NUTRITION CENTER IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM LEVEL OF HEALTH AND TO EDUCATE EACH PERSON SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC, THEN IN TURN, EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition, as she deems appropriate through the use of manipulation throughout my body. It is understood and agreed the amount paid the doctor for labs/x-rays is for examination, and the results will remain property of this office, being on file where they may be seen at any time while a patient of this office. 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.

Patient's Signature_____Date_____

Guardian/Spouse Signature Authorizing Care_____

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