



Dr. Mehran Soudbakhsh
Chiropractic Physician

3900 N. Rancho Dr. Suite 107 Las Vegas, Nevada 89130

www.chiropracticlv.com

Telephone: (702) 658-1681

Email: info@chiropracticlv.com

Facsimile: (702) 737-6390

Date _____ Email: _____ Home Phone _____

Patient Last Name _____ First Name _____ Middle Initial _____

Responsible Party (if a minor) _____

Street Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse (or responsible party) Name _____ Birthdate _____

Business Name and Address _____

Occupation _____ Business Phone _____

Who is responsible for the account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? No Yes, if yes.

Name of Primary Insurer _____

Contract # _____ Group # _____ Subscriber _____

Name of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber _____

In case of emergency, who should be notified? _____ Phone _____

How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with (Name of Insurance) _____ and assign directly to Dr. **Mehran Soudbakhsh** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____



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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Doctor Patient

I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the number listed below 24 hours a day for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room.

If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent, with the doctor, as indicated by our initials. I have also had an opportunity to ask questions about its content, 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 conditions for which I seek treatment.

Initials

To be completed by the patient:

Print Patient's Name

Signature of Patient
(or parent/guardian)

Date Signed

Doctor's Signature



PAIN DIAGRAM

NAME _____

DATE ____/____/____

PLEASE COMPLETE THE FOLLOWING "PAIN DIAGRAM" BY USING LETTERS ON THE RIGHT TO INDICATE YOUR AREAS OF PAIN ON THE DIAGRAM:

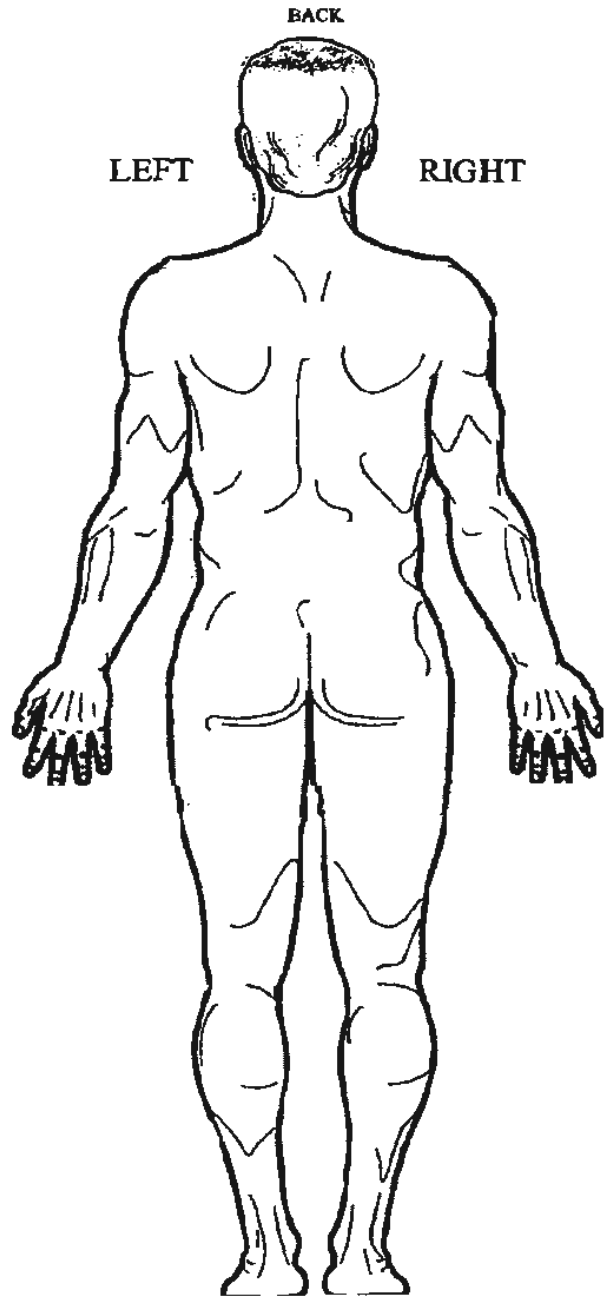
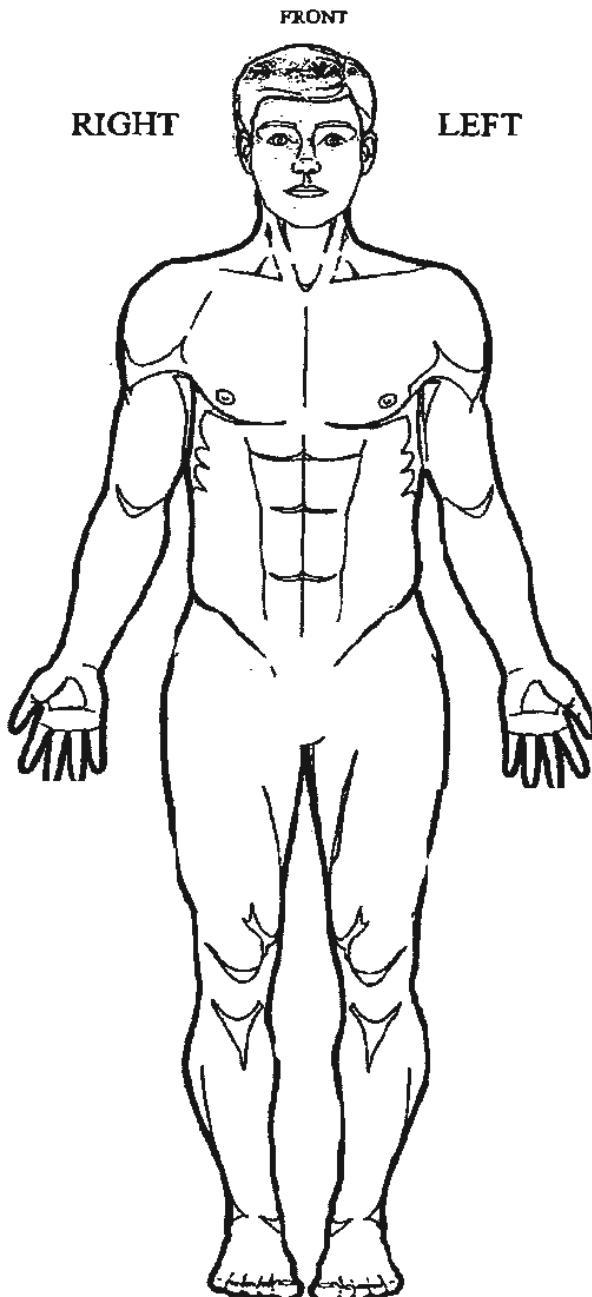
Rate your pain intensity 0 = No Pain 10 = Extreme Pain

- 1. Right Now 0 1 2 3 4 5 6 7 8 9 10
- 2. At its BEST 0 1 2 3 4 5 6 7 8 9 10
- 3. At its WORST 0 1 2 3 4 5 6 7 8 9 10

Types of PAIN:

- T. TINGLING
- B. BURNING
- D. DULL
- S. SHARP/STABBING
- N. NUMBNESS
- H. STIFFNESS
- A. ACHY

PATIENT'S SIGNATURE _____





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Patient Name: _____

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the Present column. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

- | Past | Present | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (chronic lung disorders) |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain (R_____ L_____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack (date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders (by condition) |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver / Gallbladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite |

- | Past | Present | Condition |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Ankle or Foot (R_____ L_____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Lower Leg or Knee (R_____ L_____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm or Elbow (R_____ L_____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Leg or Hip (R_____ L_____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain (R_____ L_____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling, Stiffness of Joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor, Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain (R_____ L_____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

If a family member has had any of the following, please mark the appropriate box:

- | | |
|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Chronic Back Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a permanent disability rating?
Location _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Date rating received ____/____/____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rating Percentage _____% |

Present Weight _____ pounds Height _____ feet _____ inches

Please check any of the following that apply to you

- | Past | Present | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # births _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills, type _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications (list if not listed elsewhere)
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations/Surgical Procedures (list if not described elsewhere)
_____ |

- | Past | Present | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Coffee/Tea/Caffinated Soft drinks:
cups/cans per day _____ |

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature: _____

Date: _____