Body of Beverly Hills Wellness

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Michael Kaliko, D.C. **Ruben Chldryan, D.C.**

1. Please enter your information.

First Name: ______ Middle Name: ______ Last Name: ______

Date of Birth: ______ Weight: ______ Height: ______ Gender: ______ Social Security's Number ______

Marital Status: ______ Street Address: ______ Apt./Unit #: ______

City: ______ State: ______ Zip Code: ______

Email: ______ Mobile Phone: ______

2. Please provide your attorney information below:

Attorney information: ______ Phone #: ______

3. Please upload a form of identification. (Please upload a photo of your ID or passport)

4. Medical History:

Do you have pre-existing medical conditions?

☐ Yes ☐ No pre-existing medical conditions reported.

If answered yes above; please list all known medical conditions

______

Do you have any known allergies or sensitivity's?

☐ Yes ☐ No known allergies or sensitivity's reported.

If answered yes; please list all known allergies or sensitivity's

______

Do you have any family members with medical conditions?

☐ Yes ☐ No known family members with medical conditions reported

If answered yes; please list all known family medical conditions.

______

5. Surgical & Hospitalization History:

Have you had any surgical procedures before?
☐ Yes ☐ No previous surgical history reported

If answered yes; please list what surgery's were performed and when?

____

Have you been hospitalized for any other known injuries or illnesses?
☐ Yes ☐ No hospitalizations or other injuries reported

If answered yes; please list what hospitalizations have you experienced and when?

____

6. Medications & Supplement History:

Are you taking medications or health supplements?
☐ Yes ☐ No medications or health supplements reported

if answered yes above, please list all known medications or supplements

____

7. Prior collision or slip and fall injuries

Prior to your collision today, have you been involved in any other auto collisions or slip and fall?
☐ Yes ☐ No

Please list the all other collisions or injury's that you have experienced

____

8. Review of Systems: Please select which pain or discomfort you have experienced prior the collision or injuries.

Musculoskeletal:
☐ None apply ☐ poor posture ☐ muscle pain
☐ hip Pain ☐ sciatica ☐ spinal curvature
☐ shoulder pain ☐ foot pain ☐ low back pain
☐ joint pain ☐ swelling ☐ neck pain
☐ difficulty chewing / clicking jaw ☐ stiffness
☐ gout ☐ arthritis

Skin:
☐ None apply ☐ rash / sores
☐ lesions ☐ itchiness
☐ changes in hair and nails

Urinary:
☐ None apply ☐ kidney stones / kidney infection
☐ painful / excessive urination ☐ blood in urine
☐ bladder leakage ☐ UTI ☐ prostate infection

General Health:
☐ None apply ☐ loss of sleep ☐ sweats ☐ chills
☐ fatigue ☐ stress

Respiratory:
☐ None apply ☐ chest pain ☐ coughing
☐ wheezing ☐ fever ☐ shortness of breath
☐ phlegm ☐ emphysema / bronchitis

Ent:
☐ None apply ☐ ear aches ☐ sinus pressure
☐ dental Problems ☐ hearing loss ☐ vertigo
☐ ringing in the ears ☐ frequent sore throats
☐ vision changes or blurred vision ☐ nose bleeds
☐ flashing lights ☐ glaucoma/ cataracts

Gastro-Intestinal:
☐ None apply ☐ vomiting ☐ hemorrhoids
☐ weight trouble ☐ poor / excessive appetite
☐ constipation ☐ diarrhea
☐ abdominal Cramps / pain
☐ gallbladder problems ☐ gas / bloating
☐ black / blood stool ☐ heartburn / reflux ☐ colitis
☐ liver problems ☐ jaundice ☐ nausea

Cardiovascular:
☐ None apply ☐ palpitations ☐ murmur
☐ skipped heart beats ☐ blue fingers / toes
☐ swelling in hands / feet ☐ night sweats
☐ heart disease

Neurological:
☐ None apply ☐ numbness ☐ headaches
☐ tremors ☐ memory loss ☐ seizures ☐ paralysis
☐ fainting ☐ feeling "pins and needles" or tingling
☐ loss of strength

9. Social History intake:

Check your daily usage	Tobacco	Rec. Drug	Alcohol	Vaping	Caffeine	Tea
1-2xs a week						
2-3xs a week						
4xs+ times a week						
No intake of usage						

10. Headaches or Migraines

Are you currently experiencing headaches or migraines, if so where is it located?
☐ No headaches or migraine reported ☐ back of head ☐ top of head ☐ right side of head
☐ left side of head ☐ frontal

How long in a day does your headaches or migraine last?
☐ 5mins - 20mins ☐ 20mins - 40mins ☐ 40mins - 60mins ☐ 1hr - 3hrs ☐ more than 3hrs+

11. Please describe the areas of pain your currently experiencing?

	Neck	Upper-back	Mid-back	Shoulder	Elbow	Hand	Low back	Hip	Leg	Knee	Foot
Right											
Left											
Both											

12. Description of pain and frequency.

Are you experiencing any radiating pain, if so where?
☐ No radiating pain is present ☐ into head ☐ eye pain ☐ neck pain ☐ upper-back pain ☐ mid-back pain
☐ right shoulder pain ☐ left shoulder pain ☐ chest pain ☐ ribs ☐ abdominal pain ☐ right elbow pain
☐ left elbow pain ☐ right forearm pain ☐ left forearm pain ☐ right hand pain ☐ left hand pain
☐ low back pain ☐ left hip pain ☐ right hip pain ☐ right leg pain ☐ left leg pain ☐ right knee pain
☐ left knee pain ☐ right foot pain ☐ left foot pain

Describe the type of pain your experiencing?

☐ sharp ☐ burning ☐ cramping ☐ pulsating ☐ stabbing ☐ tension ☐ nerve pain ☐ soreness ☐ pinching
☐ pressure ☐ muscle spasm ☐ aching ☐ pounding ☐ throbbing ☐ numbing ☐ stinging ☐ constricting
☐ dull ☐ shooting pain ☐ tingling ☐ stiffness ☐ tenderness ☐ tightness ☐ inflammation

Frequency of pain

☐ constantly ☐ frequently ☐ on and off

What is the Intensity of your pain? (1 minimal pain - 10 severe pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

13. Activities of Daily Living: How does your pain affect your mobility and daily functions.

Are your physical activities being affected?

☐ No difficulties with physical activities ☐ performing household chores ☐ getting dressed
☐ getting up from bed ☐ getting up from chair ☐ getting in car ☐ getting out of car ☐ lying down
☐ squatting ☐ lifting ☐ sitting ☐ walking ☐ kneeling ☐ driving ☐ standing ☐ sitting long periods of time
☐ walking long periods of time ☐ kneeling long periods of time ☐ driving long periods of time
☐ standing long periods of time ☐ carrying large objects ☐ carrying small objects ☐ bending forwards
☐ bending backwards ☐ bending to the left ☐ bending down ☐ bending to the right ☐ twisting right
☐ twisting left ☐ pulling things ☐ pushing things ☐ climbing stairs / inclines ☐ exercising upper-body
☐ exercising lower-body ☐ difficulties playing sports or recreational activities
☐ difficulties with communication ☐ difficulties with hand functions ☐ difficulties with concentration
☐ difficulties with sleeping patterns

14. Automobile Vehicle Information: (For your current auto collision).

Date of your injury?

____

Describes your vehicle type?

☐ Car (sedan) ☐ Suv ☐ Mini Suv ☐ Pick-up truck ☐ Commercial truck ☐ Van ☐ Bus ☐ Pedal Bike
☐ Electric bike ☐ Motorcycle ☐ Skateboard ☐ Moped ☐ Electric scooter ☐ Pedal scooter ☐ Rollerblades
☐ Train

Describes the other vehicle type ?

☐ Car (sedan) ☐ Suv ☐ Mini Suv ☐ Pick-up truck ☐ Commercial truck ☐ Van ☐ Bus ☐ Pedal Bike
☐ Electric bike ☐ Motorcycle ☐ Skateboard ☐ Moped ☐ Electric scooter ☐ Pedal scooter ☐ Rollerblades
☐ Train

What position where you in the vehicle at the time of collision?

☐ driver ☐ front passenger ☐ right rear passenger ☐ left rear passenger ☐ middle passenger

15. Collision description. (for your current auto collision)

What was your vehicle doing at the time of the collision?

☐ stopped at intersection ☐ proceeding along the road ☐ accelerating forwards ☐ at a red light
☐ at a stop sign ☐ on the freeway ☐ exiting freeway ☐ entering freeway ☐ reversing vehicle
☐ making a left turn ☐ making a right turn ☐ making U-turn ☐ attempting to park vehicle
☐ vehicle was in parked position

Position your head or body facing at the time of the collision?

☐ facing forward ☐ facing left ☐ facing right ☐ looking back ☐ Looking down ☐ Looking up

Point of impact to the vehicle?

☐ head on ☐ rear-end ☐ right front side ☐ right rear side ☐ left front side ☐ left rear side

16. Bodily injuries (for your current auto collision)

Did your head or any other part of your body strike the interior of the vehicle or your surroundings?

☐ Yes ☐ No

If yes, where did your head or body strike?

____

Did you lose consciousness ?

☐ Yes ☐ No

If marked yes, how long did you loose consciousness for?

☐ 1mins - 5mins ☐ 5mins - 15mins ☐ 15mins - 30mins ☐ +30mins

17. For your current auto collision

	Was your seatbelt on?	Able to brace for the initial impact?	Driver airbags deploy?	Passenger airbags deploy?
Yes				
No				

18. Please explain in your own words how did the collision happen?

____

____

____

____

19. Police and reporting (for your current auto collision)

Did the police arrive at the scene?

☐ Yes ☐ No

Did the fire dept arrive at the scene?

☐ Yes ☐ No

Was their an incident report created?

☐ Yes, an initial incident report was created by police

☐ Yes, an initial incident report was created by the fire dept

☐ No initial incident report was created by police ☐ No initial incident report was created by the fire dept

20. After the collision, what pain did you immediately experience?

☐ headaches ☐ neck pain ☐ upper-back pain ☐ mid-back pain ☐ right shoulder pain
☐ left shoulder pain ☐ chest pain ☐ ribs ☐ abdominal pain ☐ right forearm pain ☐ left forearm pain
☐ right hand pain ☐ left hand pain ☐ low back pain ☐ left hip pain ☐ right hip pain ☐ right leg pain
☐ left leg pain ☐ right knee pain ☐ left knee pain ☐ right foot pain ☐ left foot pain

21. Treatment History: (related to your current auto collision).

Where did you go after the collision?

☐ Home ☐ ER ☐ Urgent Care ☐ Work ☐ PCP

If answered to one of these above, (ER, urgent care or PCP) which facility did you attend and when?

____

Did you receive imaging anytime during the course of your treatment anytime in your treatment?

☐ Yes ☐ No

If answered yes above, What type of imaging was performed?

☐ X-rays ☐ MRI ☐ CT Scans ☐ Other

Which body parts was imaging performed on?

____

Have you been prescribed medication, brace or injections?

☐ Yes ☐ No

Please state which type of medication, brace or injections were you prescribed?

____

Prior to your visit today, have you consulted with other physicians for your injuries?

☐ No other consultations with any other physician is reported. ☐ Chiropractor ☐ Physical therapy
☐ Neurologist ☐ Orthopedic Surgeon ☐ Pain Management ☐ Podiatrist ☐ Acupuncturist ☐ Ent ☐ PCP
☐ other