

# Body of Beverly Hills Wellness

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## 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:	Mobile Phone:	Email:		
_____	_____	_____		

## 2. Please provide your attorney information below:

Law firm or med-pay information:	Phone #:
_____	_____

## 3. Please upload a form of identification (Please upload a photo of your ID or passport from you camera)

## 4. Medical History:

Do you have pre-existing medical conditions?

Yes  No medical conditions reported.

If answered yes above; please list all known medical conditions

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Do you have any known allergies or sensitivity's?

Yes  No known allergies or sensitivity's reported.

if answered yes, please list all know allergies or sensitivity's?

\_\_\_\_\_

Do you have any family members with medical conditions?

Yes  No family members with medical conditions reported

if answered yes, please list all known family medical conditions.

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## 5. Surgical & Hospitalization History:

Have you had any surgical procedures?

Yes  No previous surgical history reported

if answered yes, what type of surgery's were performed and when?

Have you been hospitalized for any other known injuries or illnesses?

Yes  No reported hospitalizations or other injuries reported

if answered yes, Please list what hospitalizations have you've been involved in and when?

**6. Prior injuries or auto collisions (this information is based on past injuies)**

Have you been involved in any other collisions or injury's?

Yes  No other collisions or injuries reported

if answered yes, please list all other collisions or injury's that have occurred.

**7. Medications & Supplement History:**

Are you intaking any medications or health supplements?

Yes  No intake of medications or health supplements reported

if answered yes, lease list all known medications or supplements

**8. Social History intake:**

Social Intake	Tobacco	Rec. Drugs	Alcohol	Vape	Caffine	Tea
4+xs a week						
2-3xs a week						
1-2xs a week						
No usage						

**9. Which of these have you experienced prior to your injuries today.**

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

Urinary:

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

Neurological:

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

Cardiovascular:

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

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

General Health:

- None apply  loss of sleep  sweats  chills
- fatigue  stress

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 mark all your current pain locations that apply below.

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

12. Description of pain, frequency & activities of daily living.

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  Occasionally

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

- 1  2  3  4  5  6  7  8  9  10

Are your physical activities being affected?

- No difficulties with performing daily or physical activities
- performing household chores
- getting dressed
- 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 physical activities
- difficulties with communication
- difficulties with hand functions
- difficulties with concentration
- difficulties with senses
- difficulties with sleeping

### 13. Injury incident information (this information is based on your current injuries)

Date of your injury?

\_\_\_\_\_

What type of injury did you experience?

- Slip and fall
- Dog bite / dog assault
- Struck by falling object
- Assault by pedestrian
- Crushed

Please state the incident Location & time of incident

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When did the incident occur?

- While entering
- While exiting
- Inside premises
- Outside premises
- passing through premises

Please describe the conditions of the incident

- uneven floors/tiles or stairs
- inadequate guarding or hazards
- insufficient lighting
- cracked pavement
- holes in flooring
- poorly placed fixtures
- inadequate warning signage
- snow, ice, wet spots
- electrical cords
- grease and polished floors
- potholes
- loose doors or windows
- Bunched rugs
- slippery / wet conditions (spills and food)
- tripping hazards / congestion in area
- Open drawers or filing cabinets
- shifting gravel
- Not properly maintained
- dog not on a leash
- stray dog attack
- Falling tree / branch
- Falling signage
- Falling equipment / merchandise
- at a restaurant
- at the mall
- at a cooperate building
- at a nightclub
- at a bar
- at a medical office
- at a school
- at home
- at work
- at supermarket
- at a retail store

Where they any visible markings, head or body trauma?

- head trauma
- body hit the surroundings
- Contusion/bruises
- Abrasion/Scratches
- Fractures
- Sprain/Strains
- Laceration/Cuts
- Bites
- bleeding
- Punctures
- Infections
- Rabies

Was their an incident report created?

- Yes, incident report was created by law enforcement
- Yes, incident report was created by store management.
- Yes, incident report was created by a healthcare professional
- Yes, incident report was created by a restaurant management.
- Yes, incident report was created by security guard
- No, initial incident report was created at the time of the injury

### 14. What type of pain did you experience after you were injured?

- 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

**15. Please describe in your own words, how did your injuries occur?**

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**16. Treatment History: (Questions are related to your current injuries).**

Where did you go after your injuries?

- Home
- ER
- Urgent Care
- Work
- PCP

if answered yes, Which facility did you go to and when?

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Did the urgent care, hospital or PCP recommend imaging ?

- Yes
- No

What type of imaging was performed?

- X-rays
- MRI
- CT Scans
- Ultrasound
- Other

Were you prescribed medication, brace or injections?

- Yes, i was prescribed medication
- Yes, i was prescribed a brace
- Yes, i was prescribed injections
- No, i was not prescribed neither a brace, medication or injections
- No, i was not prescribed medication
- No, i was not prescribed a brace or injections

Which type of medications or brace were you prescribed?

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Prior to your visit today, have you consulted with any of these physicians for your current injuries?

- Prior to today, no other consultations with any other physician is reported.
- Chiropractor
- Physical therapy
- Neurologist
- Orthopedist
- Orthopedic Surgeon
- Pain Management
- Podiatrist
- Acupuncturist
- ENT
- PCP
- Other