Body of Beverly Hills Wellness

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Michael Kaliko, D.C.

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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

_____

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.

_____

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

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

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

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

_____

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?

_____

_____

_____

_____

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?

_____

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?

_____

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