Joshua Tree Chiropractic
New Client Questionnaire

Have you received the vaccination for Covid-19? Yes / No

Who referred you? (circle one) Friend / Family / Google / Yelp / Insurance _____

PRACTICE MEMBER INFO

Name_____

Age _____ Birth date ___/____/____

Height _____ Weight _____

Email_____

**Email and snail mail. ▫ Opt out*

Address_____

City _____

Zip _____

Phone (cell)_____

**You may be sent a text reminder of your appointment. ▫ Opt out*

Occupation/Employer

_____

Emergency contact _____

Relationship _____

Phone _____

Have you been under Chiropractic care before? ❑Yes ❑No

Do you have a desk job? ❑No ❑Yes

Has your workstation been ergonomically evaluated? ❑No ❑Yes

Are any of these conditions due to an accident? ❑No ❑Yes
If Yes,what type?

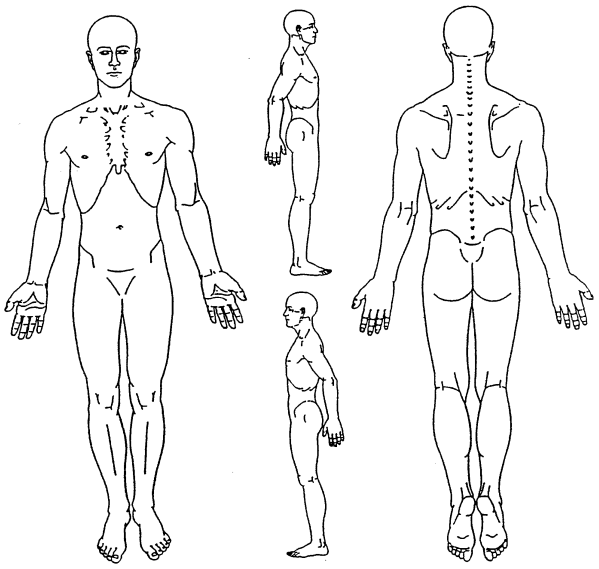
CURRENT COMPLAINTS

Primary reason for visit
1._____ Pain ___/10

Secondary reasons

2._____ Pain ___/10
3._____ Pain ___/10

Mark an X where you have pain or discomfort.



Have you been told you have problems/defects in your spine or nervous system? If yes, what?_____

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New Client Questionnaire

When did your symptoms first appear?

_____

What do you think caused it?

_____

What aggravates or makes the condition worse?

_____

What makes it better?

_____

Is this condition getting progressively worse:
❑Yes ❑No ❑uncertain

Type of pain or discomfort:

❑Sharp ❑Dull ❑Ache ❑Shooting ❑Stabbing ❑Tight ❑Burning ❑Numbness ❑Tingling ❑Swelling ❑Itching

Does the pain move or radiate?
If yes, where? _____

Overall Frequency of complaint (time):
❑ 100% - Constant
❑ 75% - Frequent
❑ 50% - Intermittent
❑ 25% - Occasional

Let us know if you have been under a diagnosis or experience any of the following:

❑ Neurological (balance,dizziness)
❑ Respiratory (asthma,allergies)
❑ Cardiovascular (stroke, high BP)
❑ Reproductive issues
❑ Gastrointestinal issues
❑ Mental Health(depression,anxiety)
❑ Dermatological (eczema,hives)
❑ Headaches (#_____/week/month)
❑ High stress (#_____/days/month)
❑ Hormonal issues

Do you take pharmaceutical drugs?
If so, which ones and why?

_____

_____

_____

Office Use Only*

History of Trauma/Surgeries/Hospitalizations

_____

_____

_____

Joshua Tree Chiropractic
Office Policies

Informed Consent: I understand that in the practice of chiropractic, **there are musculoskeletal and neurological risks to receiving chiropractic adjustments**. I do expect the doctor to exercise judgment during the course of the procedures which the doctor feels are in my best interests, at the time, based upon the facts then known. **I understand the above consent**. I have also had the opportunity to ask questions about its contents, and by signing below I agree to care recommended and performed by my chiropractor. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Dr. Joshua Pollack D.C. and/or any other licensed D.C. working in this office. It is important that you understand, as with all health care approaches, **results are not guaranteed, and there is no promise to cure**. As with all types of health care interventions, **there are some risks to care**, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains and sprains.

Terms of Acceptance/Payment Responsibility: We aim to provide you with superior health care. We ask that you render payment at the time of service however credit card charges may not occur the same day. Joshua Tree Chiropractic will do its best to confirm your eligibility and benefits with your insurance provider early in your care plan to reduce any potential unknown costs to you. Cash rates will be applied at **$150 for initial exam/adjustment** and **$85 for all following visits** unless otherwise agreed in writing by the doctor. All clients using a **credit card or digital payment solution (i.e. Venmo) will be assessed a $1.25 or 3% processing fee per transaction.** Cash and checks are always accepted with no processing fees.

Cancellation & No-Show Policy: We understand that unanticipated events occasionally do happen in everyone's life. We kindly ask that **you give at least a 12 hour advance notice when canceling** and/or changing an appointment. Text message requests are accepted and preferred. A **$40 cancellation fee will be rendered for all late cancellations** and must be paid in full before the next visit. Anyone who either forgets or consciously chooses to forgo their scheduled appointment time will be considered a "no-show" and **will be charged $60 for the "missed" appointment. Personal Injury cases** will be billed per a usual visit.

Privacy: Chiropractic services will be provided in an **open room** where other patients are also receiving care. Other persons in the office may overhear some of your personal information during the course of care. Should you need to speak with the doctor at any time in private, a place for these conversations will be provided upon request.

I have read and understand the above and **I hereby give permission** for Dr. Joshua Pollack to continue with my, and/or my child's initial consultation, assessment, and adjustment(s).

I agree with all of the statements above,

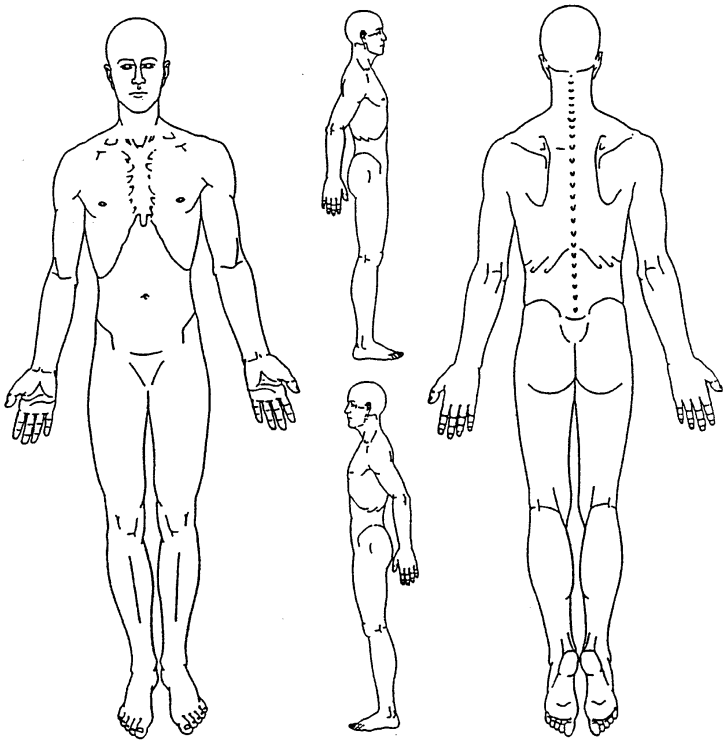
_____	_____	_____
Client / Guardian Name (Please print)	Signature	Date

Joshua Tree Chiropractic
Exam Findings

Office Use Only*

Range of Motion

Posture Analysis



Cervical

Rotation restriction - R / L - Pain / TT
Lateral Flex restriction - R / L -Pain / TT

Ext / Flex - Pain / TT
Shoulder depression - R / L - Pain / TT
Extension restriction - Pain / TT
Rotation restriction - R / L - Pain / TT
Lateral flex restriction - R/L - Pain/TT

Global Tests
Valsalvas ❑
Dejerine's Triad ❑

Balance
❑ Forward/backward Sway

Listings
Cervical _____
Thoracic _____
Lumbar _____
Pelvis _____
Extremities _____

Re-evaluation - Date _____
What have you noticed since beginning care?

_____

_____