



437 South Highway 101 Suite 202
Solana Beach, CA 92075
858-792-0754

Anthony Chadwell, H.H.P.

Date: _____

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone :(H) _____ Phone :(W) _____

Phone :(C) _____

E-Mail: _____ May we contact you: Yes/ No

Referred By: _____

Date of Birth (month/date/year): _____ Age: _____

How "old" do you feel? _____

Occupation: _____ Do you enjoy what you do? _____

Marital Status: _____ Children: Yes/ No Names and Ages: _____

Are you under a doctor's care? If yes, please give name, reason, and date of last visit.

Are you currently taking any Medications? If yes, please list and indicate why and how long you have been taking them.

1 _____ 3 _____

2 _____ 4 _____

Are you currently taking any Vitamins/ Supplements?

1 _____ 3 _____

2 _____ 4 _____

Ever visit a chiropractor? Who, when, why, and what was your experience? _____

Is there any physical pain anywhere in your body right now? Where and for how long?

Any known allergies or sensitivities? _____

Any foods you don't eat? _____

Please list any surgeries and dates. _____

Please list any accidents and dates.

Have you been to a counselor/therapist before? How long ago was that? What did you enjoy most about it? How could it have been better for you?

Have you tried any of the following techniques? If yes, when? And how successful were they for you?

*Muscle testing _____ *Cranial Sacral Therapy _____

*Hypnosis _____ *Neuromuscular Therapy or massage _____

*Meditation _____ *Visualization _____

*Prayer _____ *Yoga _____

What would your ideal outcome of today's visit be?

Please carefully read and initial the following:

_____ I am 18 years old or older. If not, I have provided written permission from my parents or legal guardian to participate in treatment.

_____ I understand that my success is directly related to my readiness to change and my level of commitment to my personal growth.

_____ I understand that payment is expected at the time of service. I may choose to submit a receipt of this visit to my insurance company for reimbursement but that it is my responsibility to secure whatever reimbursement, if any, according to the policies and procedures of my insurance carrier.

_____ I understand that there is a **24 hour cancellation policy**. Or, I will be billed for the scheduled visit and asked to pre-pay for subsequent visits.

_____ I understand that Anthony Chadwell is not a Physician and does not Diagnose or Treat Disease.

Print Name

Signature

Date

