Confidential Patient Information

Name ______________________ Address ______________________

City ____________ State ____ Zip ________ Home phn ____________ Cell phn ____________

Drivers Lic# __________ Email Home: ______________ Email Work: ______________

SSN ____________ Date of Birth __________ Age ________ Height ________ Weight ________

Male __ Female __ Single __ Married __ Divorced __ # of children __ Name of spouse (or parent) ____________

Employer ______________________ Address ______________________

City ____________ State ____ Zip ________ Wk phn ____________ Occupation ____________

What is the name of your family physician? ____________ What city are they located in? ____________

Have you ever had Chiropractic care before? ___ If yes, doctor name: ____________ Date of last visit ____

If you are experiencing any pain (neck pain, low back pain, etc), health problems, symptoms, and/or complaints, please list in order of severity:

1. ______________________ For how long? ______________________
2. ______________________ For how long? ______________________
3. ______________________ For how long? ______________________
4. ______________________ For how long? ______________________

Has this problem been getting worse or staying the same? ______________________

Currently or in the past have you ever experienced any of these complaints while working? ____ If yes, please describe what activities at work may be causing you to experience these complaints: ______________________

Are there any other activities, incidents, or events outside of work that may have caused these complaints? ________ If yes, please explain: ______________________

Have you at any time in the past ever suffered a work injury? ____ If yes, what is the date of injury? ____________

Do you have an attorney representing you for this work injury? __ Yes __No Name of attorney____________

Have you been involved in an auto accident in the last 12 months? __ Yes __ No If yes, what is the date of accident? ________

How many other passengers were in the car with you? ______________________

List other doctors consulted for these conditions: 1.______________ 2. ______________

If due to an auto accident, what is the name of your auto insurance company? ______________

Have you ever had any surgeries of hospitalizations? ____ If yes, please list: ______________

Please list any current or past injuries and illnesses not listed above: ______________

Please check all medications (over the counter and/or prescribed) you are currently taking: __ Aspirin/Tylenol __ Pain killers __ Muscle Relaxers __ Insulin __ Birth Control Pills __ Sleeping pills __ Anti-depressants __ Others ____________

Health Insurance Co. Name ______________________ Policyholder ______________

Name of Spouse's health insurance (If applicable) ____________ Policyholder______________

Spouse's Health Insurance Claims address ______________________

Policy number ______________________

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing)/ In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

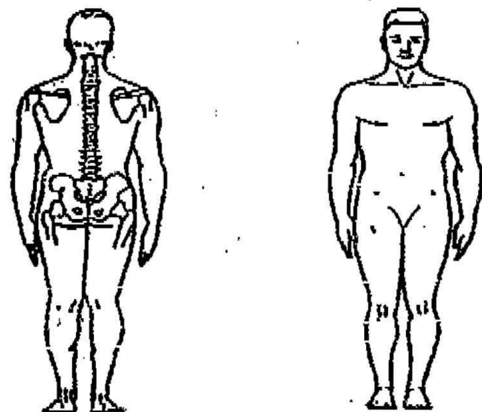
0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc. ______
2. RECREATION: hobbies, sports, and other similar leisure time activities. ______
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. ______
4. OCCUPATION: activities that are a part of directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. ______
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) ______
6. LIFE SUPPORT ACTIVITY: basic life behaviors such as eating, sleeping, and breathing. ______

If you are experiencing any health problems, please mark the exact location on the diagram below. Also describe the type of frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



NOTICE: NOT ALL PATIENTS REQUIRE XRAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOU'RE EXAMINATION WARRANTS X-RAYS ANALYSIS THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your s-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient Signature______________________________ Date ____________