

Welcome To Our Clinic

Name _____ Address _____

City _____ State _____ Zip _____ Home Phone _____ Cell _____

E-mail: _____ SSN: _____ Date Of Birth _____ Age _____

Height _____ Weight _____ Male Female Single Married Divorced # of Children _____ Name of Spouse(or parent) _____

Employer _____ Address _____

City _____ State _____ Zip _____ Work Phone _____ Occupation _____

Have you ever had Chiropractic care before? Yes No If yes, when? _____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

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 that 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? _____ Have you been involved in an auto accident in the last 12 months? Yes No If yes, Date of Accident? _____ How many other passengers were in the care 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? _____

Policy Holder Name _____ Policy Number _____ Telephone Number _____

Claims Address _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any injuries or illnesses that you have had that are not listed above: _____

Please indicate medications (over the counter)/prescriptions you are currently taking:

Aspirin/Tylenol Ibuprofen(Motrin/Advil) Pain Killers Muscle Relaxants Insulin Tranquilizers Birth Control Pills Others _____

Health Insurance Company Name _____ Policy Holder _____

Name of Spouse's Health Insurance (If applicable) _____ Policy Holder _____

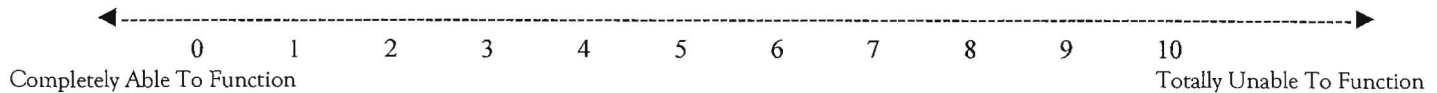
Spouse's Health Insurance Claims address _____ Policy Holder _____

Name of Personal Family Physician _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

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 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.

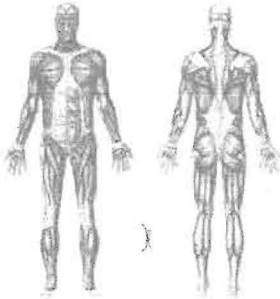
For each of the six categories of daily living, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. A score of 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented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



1. FAMILY/HOME RESPONSIBILITIES: including chores around the house (yard work, doing dishes, errands, driving). _____
2. RECREATION: hobbies, sports, and other similar leisure time activities. _____
3. SOCIAL ACTIVITY: activities with friends, including parties, theatre, concerts, dining out and other social functions. _____
4. OCCUPATION: activities that are part of or directly related to one's job including nonpaying jobs such as a homemaker, or volunteer. _____
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 supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location of you pain on the diagram below. Also describe the type and frequency of your pain. For example; Dull, Sharp, Constant, Off and On, When Standing, Sitting, Walking etc.

COMPLETE THESE DIAGRAMS



Symptoms you experience right after the accident or a few days later;

- Headache
- Pain behind the Eyes
- Tension
- Nausea
- Dizziness
- Neck Pain
- Neck Stiffness
- Mid Back Pain
- Low Back Pain
- Toe Numbness
- Cold Hands
- Cold Feet
- Chest Pain
- Shortness of Breath
- Sleeping Problems
- Nervousness
- Irritability
- Diarrhea
- Constipation
- Fainting
- Fatigue
- Confusion
- Loss of Taste
- Depression
- Ringing in the Ears
- Anxious
- Loss of Smell
- Other _____

Method of payment for today's charges: CASH CHECK CREDIT CARD _____ OTHER _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY 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 X-rays. The film itself is the property of this office. Film may be loaned to another facility for a maximum of 30 days, with authorization only.

By signing below you give the doctor permission to discuss and/or forward the findings of your examination to your personal physician named above.

I authorize this office to release any information necessary to expedite insurance claims. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I further understand that by signing below I give the doctor full authority and permission to discuss and/or forward the findings of my examination and treatments to my personal physician named above. **I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment regardless of insurance coverage or if lien's are not satisfied.**

Patient's Signature _____ Date _____