

Patient ID: _____



CHIROPRACTIC
HEALTH & SPINE

Confidential Patient Information

If you need any assistance completing this form, please ask the receptionist.

Identifying Information

Today's Date:		Date of Birth:		Age:	
Name:			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Address:		City:		State:	Zip:
Social Security Number:			Driver's License Number:		
Home Phone:			Work Phone:		
Cell Phone:		Email Address:			
May We Contact You Using Any of the Above Methods? <input type="checkbox"/> Yes <input type="checkbox"/> No				Preferred Method:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other:					
Name of Spouse/Partner or Nearest Relative:				Phone #:	
Number of Children:		Ages of Children: _____			
State your HEIGHT:			State your WEIGHT:		

Please Indicate How You Were Referred to Our Office

<input type="checkbox"/> TV	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Direct Mail	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Radio Station	<input type="checkbox"/> Internet
<input type="checkbox"/> Self	<input type="checkbox"/> Office Website	<input type="checkbox"/> Office Location		<input type="checkbox"/> Office Sign	<input type="checkbox"/> Dr. Garcia
<input type="checkbox"/> Patient of Dr. Garcia (Name):			<input type="checkbox"/> Friend (Name):		
<input type="checkbox"/> Family Member (Name):			<input type="checkbox"/> Staff Member (Name):		
<input type="checkbox"/> Attorney (Name):			<input type="checkbox"/> Screening (Where):		
<input type="checkbox"/> Other Doctor's Office (Name):					

Employment and Payment Options

Payment for Services: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Health Insurance <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Other					
Name of Insurance Company:			Insured's SSN or ID#:		
Insured's Employer:			Employer's Phone #:		
Secondary Insurance Coverage: <input type="checkbox"/> No <input type="checkbox"/> Yes: Name _____					
Occupation:			Employer:		

Females ONLY

Are You Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Last Menstrual Cycle:	
Using Birth Control? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, How Long?	
Method of Birth Control:			

Signature: _____

Date: _____

Patient History

Anything pertinent to your visit today?

Weight Frequently Required to Lift is Under: 10 lbs. 20 lbs. 30 lbs. 40 lbs.

Lifting/Bending is Less Than: 30 min 1 Hr. 2 Hrs. 3 Hrs. 4 Hrs.

Date of last physical exam: _____ Date of last lab (Blood, Urine, Stool): _____

Have you ever experienced a stroke? Yes No If Yes, Date of Stroke: _____

Have you ever experienced blood clots? Yes No If Yes, Date: _____ and Location: _____

Are you taking any blood thinning medication? Yes No If Yes, Name of Medication: _____

Have you ever had a metal implant? Yes No If Yes, Date: _____ and Location: _____

Have you ever been gunshot? Yes No If Yes, Date: _____ and Location: _____

Social History: Alcohol Use Non-Alcohol Use Smoker Non-Smoker

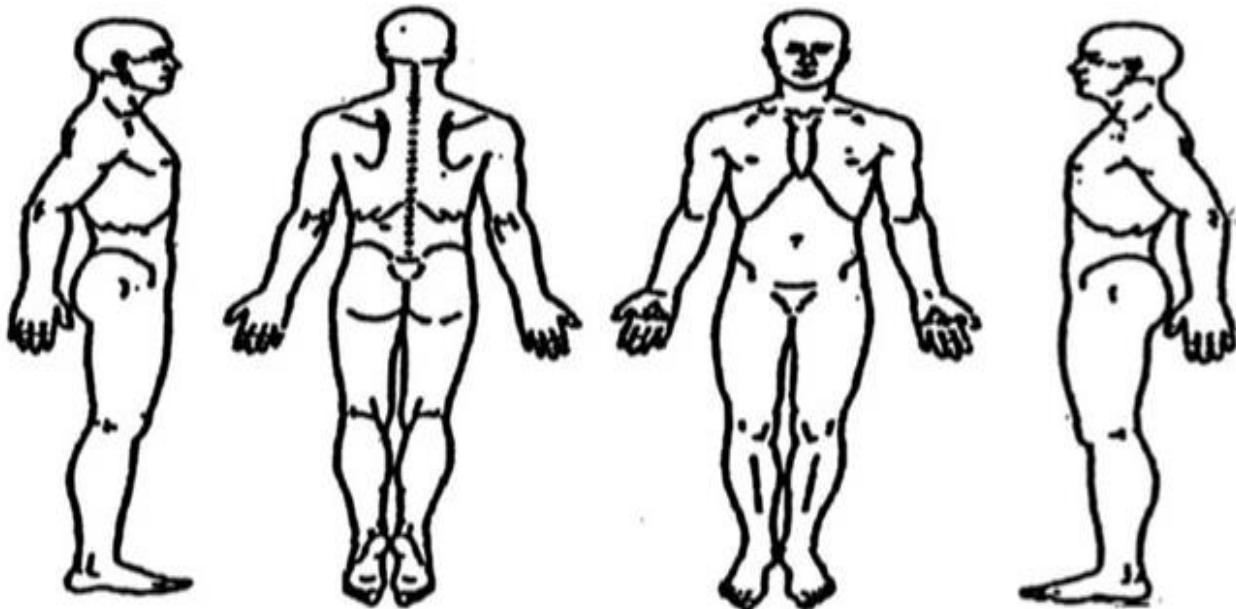
Have you ever tried to “crack,” “adjust,” “manipulate,” or “pop” your neck, back, etc.? No Yes (Please describe)

Have you ever tried to have a non-professional “crack,” “adjust,” “manipulate,” or “pop” your neck, back, etc.?
 No Yes (Please describe)

Is today’s problem caused by: Auto Accident Workman’s Compensation

What are your chief complaints for this visit?

Indicate on the drawings below where you have pain/symptoms.



Signature: _____

Date: _____

History of Current Complaint(s)

Complaint – Please List ONLY ONE complaint per sheet.

Describe Complaint:

How often do you experience your symptoms?
 Constant (76-100% of the time)
 Frequent (51-75% of the time)
 Occasional (26-50% of the time)
 Intermittent (1-25% of the time)

How would you describe the type of pain?

- | | | | | |
|----------------------------------|-----------------------------------|---------------------------------|---|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Achy | <input type="checkbox"/> Stiff | <input type="checkbox"/> Sharp with Motion | <input type="checkbox"/> Electric-like with Motion |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Burning | <input type="checkbox"/> Numb | <input type="checkbox"/> Shooting with Motion | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Shooting | <input type="checkbox"/> Tingly | <input type="checkbox"/> Stabbing with Motion | |

How are your symptoms changing with time?
 Getting Worse
 Staying the Same
 Getting Better

Pain Scale

- | |
|--|
| 0 - I have no pain. |
| 1 - I have very light pain. Most of the time I do not think about it. |
| 2 - I have mild pain and aches. |
| 3 - I have uncomfortable pain but I can usually tolerate it. |
| 4 - I have bad pain that can be ignored if I am busy but it is still distracting. |
| 5 - I have bad pain that I cannot ignore more than 30 minutes. Limits activities. |
| 6 - I have intense pain interfering with daily activities and cannot be ignored. |
| 7 - I have very intense pain. It is difficult to think, sleep and function. |
| 8 - I have pain so intense it is hard to walk and talk and is disabling. |
| 9 - I am unable to speak other than cry out or moan due to my pain. |
| 10 - I hurt so bad it causes me to pass out. |

Circle the level of
pain you are
experiencing with
this problem.

How much has the problem interfered with your work?
 Not at all
 A little bit
 Moderately
 Quite a bit
 Extremely

How much has the problem interfered with your social activities
 Not at all
 A little bit
 Moderately
 Quite a bit
 Extremely

Who else have you seen for this problem?

- | | | |
|---|---|---|
| <input type="checkbox"/> Doctor of Chiropractic | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER Physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Nobody |

How long have you had this problem?

How do you think your problem began?

Do you consider this problem to be severe?

- Yes At Times No

What aggravates your problem?

What relieves the problem?

What concerns you the most about your problem?

What does it prevent you from doing?

Signature: _____

Date: _____

Complaint – Please List ONLY ONE complaint per sheet.

Describe Complaint:

How often do you experience your symptoms?

- Constant (76-100% of the time) Frequent (51-75% of the time)
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How would you describe the type of pain?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with Motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with Motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with Motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric-like with Motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: |

How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

Pain Scale

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Circle the level of pain you are experiencing with this problem.

How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

How much has the problem interfered with your social activities

- Not at all A little bit Moderately Quite a bit Extremely

Who else have you seen for this problem?

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How do you think your problem began?

Do you consider this problem to be severe?

- Yes At Times No

What aggravates your problem?

What relieves your problem?

What concerns you the most about your problem?

What does it prevent you from doing?

Signature: _____

Date: _____

Patient History

What is your: Height _____ Weight _____ Date of Birth ___/___/___ Occupation _____

 How would you rate your overall health? Excellent Very Good Good Fair Poor

 What type of exercise do you do? Strenuous Moderate Light None

Indicate if you have any immediate family members with any of the following:
 Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS

For each of the conditions listed below, check the box for “past” if you have had the condition in the past. If you presently have a condition listed below, check the box in the “present” column.

<input type="checkbox"/> Past <input type="checkbox"/> Present Headaches <input type="checkbox"/> Past <input type="checkbox"/> Present Neck Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Upper Back Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Mid Back Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Low Back Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Shoulder Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Elbow/Upper Arm Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Wrist Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Hand Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Hip Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Upper Leg Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Knee Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Ankle/Foot Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Jaw Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Joint Pain/Stiffness <input type="checkbox"/> Past <input type="checkbox"/> Present Arthritis <input type="checkbox"/> Past <input type="checkbox"/> Present Rheumatoid Arthritis <input type="checkbox"/> Past <input type="checkbox"/> Present Cancer <input type="checkbox"/> Past <input type="checkbox"/> Present Tumor <input type="checkbox"/> Past <input type="checkbox"/> Present Asthma <input type="checkbox"/> Past <input type="checkbox"/> Present Chronic Sinusitis <input type="checkbox"/> Past <input type="checkbox"/> Present Other (Please Describe):	<input type="checkbox"/> Past <input type="checkbox"/> Present High Blood Pressure <input type="checkbox"/> Past <input type="checkbox"/> Present Heart Attack <input type="checkbox"/> Past <input type="checkbox"/> Present Chest Pains <input type="checkbox"/> Past <input type="checkbox"/> Present Stroke <input type="checkbox"/> Past <input type="checkbox"/> Present Angina <input type="checkbox"/> Past <input type="checkbox"/> Present Kidney Stones <input type="checkbox"/> Past <input type="checkbox"/> Present Kidney Disorders <input type="checkbox"/> Past <input type="checkbox"/> Present Bladder Infection <input type="checkbox"/> Past <input type="checkbox"/> Present Painful Urination <input type="checkbox"/> Past <input type="checkbox"/> Present Loss of Bladder Control <input type="checkbox"/> Past <input type="checkbox"/> Present Prostate Problems <input type="checkbox"/> Past <input type="checkbox"/> Present Abnormal Weight Gain/Loss <input type="checkbox"/> Past <input type="checkbox"/> Present Loss of Appetite <input type="checkbox"/> Past <input type="checkbox"/> Present Abdominal Pain <input type="checkbox"/> Past <input type="checkbox"/> Present Ulcer <input type="checkbox"/> Past <input type="checkbox"/> Present Hepatitis <input type="checkbox"/> Past <input type="checkbox"/> Present Liver/Gall Bladder Disorder <input type="checkbox"/> Past <input type="checkbox"/> Present General Fatigue <input type="checkbox"/> Past <input type="checkbox"/> Present Muscular Coordination Loss <input type="checkbox"/> Past <input type="checkbox"/> Present Visual Disturbances <input type="checkbox"/> Past <input type="checkbox"/> Present Dizziness	<input type="checkbox"/> Past <input type="checkbox"/> Present Diabetes <input type="checkbox"/> Past <input type="checkbox"/> Present Excessive Thirst <input type="checkbox"/> Past <input type="checkbox"/> Present Frequent Urination <input type="checkbox"/> Past <input type="checkbox"/> Present Smoking/Tobacco Use <input type="checkbox"/> Past <input type="checkbox"/> Present Drug/Alcohol Dependence <input type="checkbox"/> Past <input type="checkbox"/> Present Allergies <input type="checkbox"/> Past <input type="checkbox"/> Present Depression <input type="checkbox"/> Past <input type="checkbox"/> Present Systemic Lupus <input type="checkbox"/> Past <input type="checkbox"/> Present Epilepsy <input type="checkbox"/> Past <input type="checkbox"/> Present Dermatitis/Eczema/Rash <input type="checkbox"/> Past <input type="checkbox"/> Present HIV/Aids:
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FEMALES ONLY		
<input type="checkbox"/> Past	<input type="checkbox"/> Present	Birth Control Pills
<input type="checkbox"/> Past	<input type="checkbox"/> Present	Hormone Replacement
<input type="checkbox"/> Past	<input type="checkbox"/> Present	Pregnancy

List all prescription medications and/or over-the-counter medications (ex: aspirin, Tylenol, Advil, etc.) you are currently taking.

List all of the supplements/vitamins you are currently taking.

List all of the surgical procedures you have had.

What activities do you do at work?

Sit:	<input type="checkbox"/> Most of the Day	<input type="checkbox"/> Half of the Day	<input type="checkbox"/> Very little of the Day	<input type="checkbox"/> Never
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Stand:	<input type="checkbox"/> Most of the Day	<input type="checkbox"/> Half of the Day	<input type="checkbox"/> Very little of the Day	<input type="checkbox"/> Never
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Computer Work:	<input type="checkbox"/> Most of the Day	<input type="checkbox"/> Half of the Day	<input type="checkbox"/> Very little of the Day	<input type="checkbox"/> Never
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On the Phone:	<input type="checkbox"/> Most of the Day	<input type="checkbox"/> Half of the Day	<input type="checkbox"/> Very little of the Day	<input type="checkbox"/> Never
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 What activities do you do outside of work?

Signature: _____

Date: _____