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: ☐ Male ☐ 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? ☐ Yes ☐ No	Preferred Method:		
Marital Status: ☐ Married ☐Single ☐ Divorced ☐ Separated ☐ 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

☐ TV	☐ Yellow Pages	☐ Direct Mail	☐ Newspaper	☐ Radio Station	☐ Internet
☐ Self	☐Office Website	☐Office Location		☐ Office Sign	☐ Dr. Garcia

☐ Patient of Dr. Garcia (Name):	☐ Friend (Name):
☐ Family Member (Name):	☐ Staff Member (Name):
☐ Attorney (Name):	☐ Screening (Where):
☐ Other Doctor's Office (Name):	

Employment and Payment Options

Payment for Services: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance ☐Auto Insurance ☐ Other

Name of Insurance Company:	Insured's SSN or ID#:
Insured's Employer:	Employer's Phone #:
Secondary Insurance Coverage: ☐ No ☐ Yes: Name _____	
Occupation:	Employer:

Females ONLY

Are You Pregnant? ☐ Yes ☐ No	Date of Last Menstrual Cycle:
Using Birth Control? ☐ Yes ☐ No	If Yes, How Long?
Method of Birth Control:	

Signature: _____ Date: _____

CHIROPRACTIC
HEALTH & SPINE

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

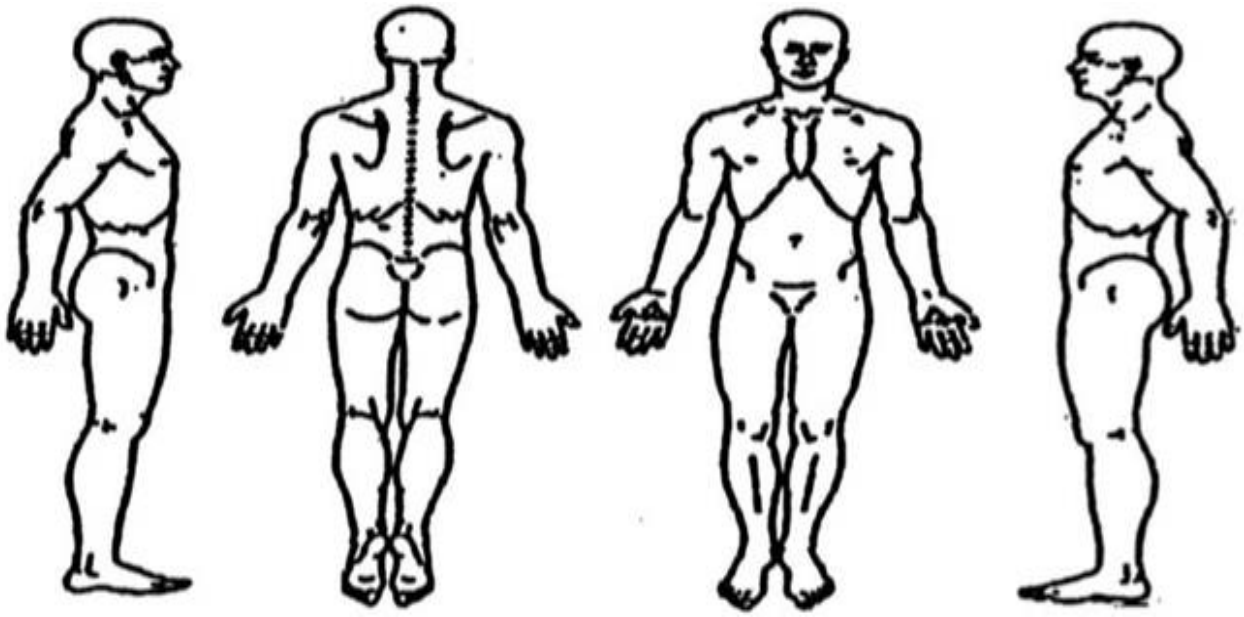
Have you ever tried to "crack," "adjust," "manipulate," or "pop" your neck, back, etc.? ☐No ☐Yes (Please describe)

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: _____

CHIROPRACTIC
HEALTH & SPINE

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.

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

☐ Past ☐ Present **Other (Please Describe):**

FEMALES ONLY		
☐ Past	☐ Present	Birth Control Pills
☐ Past	☐ Present	Hormone Replacement
☐ Past	☐ 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:	☐ Most of the Day	☐ Half of the Day	☐ Very little of the Day	☐ Never
Stand:	☐ Most of the Day	☐ Half of the Day	☐ Very little of the Day	☐ Never
Computer Work:	☐ Most of the Day	☐ Half of the Day	☐ Very little of the Day	☐ Never
On the Phone:	☐ Most of the Day	☐ Half of the Day	☐ Very little of the Day	☐ Never

What activities do you do outside of work?

Signature: _____ Date: _____

CHIROPRACTIC
HEALTH & SPINE

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?

☐ Sharp	☐ Achy	☐ Stiff	☐Sharp with Motion	☐ Electric-like with Motion
☐ Dull	☐ Burning	☐ Numb	☐ Shooting with Motion	☐ Other:
☐ Diffuse	☐ Shooting	☐ Tingly	☐ Stabbing with Motion	

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

Pain Scale

0 - I have no pain.	**Circle the level of pain you are experiencing with this problem.**
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.	

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?

☐Doctor of Chiropractic	☐Neurologist	☐Primary Care Physician
☐ER Physician	☐Orthopedist	☐Other:
☐Massage Therapist	☐Physical Therapist	☐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: _____

CHIROPRACTIC
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