



# CALIFORNIA CHIROPRACTIC

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## Patient Information Form

### PERSONAL HISTORY

<b>Name:</b>	<b>DOB:</b> / /	<b>Age:</b>	<b>Gender:</b> M / F
<b>Full Address:</b>			
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Home:</b> ( )	<b>Cell:</b> ( )	<b>Work:</b> ( )	
<b>E-mail Address:</b>			
<b>Driver's License #:</b>		<b>Social Security #:</b>	
<b>Employer:</b>		<b>Occupation:</b>	
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <b>Name of Spouse:</b> <span style="float: right;"><b>Number of Children:</b></span>			
<b>Referred By (Please be specific):</b>			
<b>Emergency Contact(Name/Number):</b>		<b>Relationship:</b>	

### CURRENT HEALTH CONDITION

<b>Purpose of this visit:</b>	<b>When did this condition begin?</b>
<b>Has it occurred before?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Has the condition:</b> <input type="checkbox"/> Worsened <input type="checkbox"/> Stayed the same <input type="checkbox"/> Comes and goes
<b>On a scale of 1-10, 10 being the worst, rate your condition:</b>	<b>Does this condition interfere with:</b> <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Daily Activities
<b>Is condition:</b> <input type="checkbox"/> Job related <input type="checkbox"/> Auto Related <input type="checkbox"/> Home Injury <input type="checkbox"/> Fall <input type="checkbox"/> Other(Explain)	
<b>Date of Accident:</b>	<b>Time of Accident:</b> <span style="float: right;"><b>Are you, or do you think you are pregnant?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</span>
<b>Do most of your current &amp; past health issues occur on one side of your body?</b> <input type="checkbox"/> Right side <input type="checkbox"/> Left side <input type="checkbox"/> Both	
<b>Drugs you now take:</b> <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Pain killers/Muscle Relaxation <input type="checkbox"/> Blood Pressure Med <input type="checkbox"/> Insulin <input type="checkbox"/> Antidepressants <input type="checkbox"/> Others	
<b>Others doctors seen for this condition:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> OTHER	
<b>Do you suffer from any condition other than that for which you are now consulting us for?</b>	

### CURRENT HEALTH HABITS

<b>Do you smoke:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Do you have regular dentist check-ups:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Do you drink:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Do you exercise regularly:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Do you drink bottled water:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Do you belong to a gym/sports club:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Sleeping Posture:</b> <input type="checkbox"/> SIDE <input type="checkbox"/> STOMACH <input type="checkbox"/> BACK <input type="checkbox"/> RESTLESS	
<b>Rate you stress level on a scale of 1-10, (10 being the worst):</b>	

## PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations: <input type="checkbox"/> Appendix <input type="checkbox"/> Tonsils <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Hernia <input type="checkbox"/> Back Surgery <input type="checkbox"/> Broken Bones <input type="checkbox"/> Back Surgery <input type="checkbox"/> Other(Describe)
Major Accidents or Falls:
Hospitalization (other than above):
Previous Chiropractic Care: <input type="checkbox"/> YES <input type="checkbox"/> NO Dr.'s name and approx. date of last visit:

## HEALTH PROBLEMS

Check all that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Severe or Frequent Headaches  | <input type="checkbox"/> Sinus Problems/Asthma   | <input type="checkbox"/> Dizziness  |
| <input type="checkbox"/> Loss of Sleep                 | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Shingles   |
| <input type="checkbox"/> Pain Between Shoulders        | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Hepatitis  |
| <input type="checkbox"/> Frequent Neck Pain            | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer   |
| <input type="checkbox"/> Numbness or Pain in Arms/Legs | <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Anemia   |
| <input type="checkbox"/> Lower Back Problems           | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> HIV/AIDS   |
| <input type="checkbox"/> Digestive Problems            | <input type="checkbox"/> Pinched Nerve(s)        | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Ulcers/Colitis                | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Osteoporosis   |
| <input type="checkbox"/> Heart Attack/Stroke           | <input type="checkbox"/> ADD/ADHA/Autism         | <input type="checkbox"/> Thyroid <input type="checkbox"/> High <input type="checkbox"/> Low |

What most important to you?

1. **Temporary Relief** of **pain** or **discomfort**; this phase enables a person to heal.  
 Acute/Intensive Care
  2. Working on resolving the **cause of the problem**, as well as the **effect (symptoms)**. This phase is where healing occurs.  
 Correction Care
  3. **Explore** and **improve** your **abilities** and **build health and wellness**.  
 Wellness Care
- If you would like the doctor to suggest the type of care appropriate for you.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_