SAN PEDRO CHIROPRACTIC CLINIC

Patient Information

Date ____/____/_____

Full name _____

Street Address_____

City_____State____ Zip_____

E-mail _____

Sex ☐M ☐F Age___Birth date____/____/_____

Social Security Number_____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Best number to reach you at : (_____)_____

During emergency contact: (name): _____

Relationship_____Phone: (_____) _____

Occupation _____

Patient Employer/School_____

Employer/School City_____

Employer/School Phone_____

Spouse's name_____

Spouse's employer_____

How did you hear about us?

☐ Online, which website?_____

☐ Friend or family, their name?_____

☐ Event, which one?_____

Insurance Information

Please tell us what type of health insurance you have should you decide to continue care in our clinic.

☐ PPO ☐ HMO ☐ Kaiser ☐ None

Insurance Company_____

*Please give insurance card and driver's license to front desk staff to scan, we will do a complimentary benefit check.

Who is responsible for the insurance account?

☐ Self ☐ Spouse ☐ Family member

Name if not self_____

Present Condition Information

Reason for Visit_____

_____

Is this pain due to an accident? ☐ Yes ☐ No

If yes: ☐ work ☐ auto accident ☐ other_____

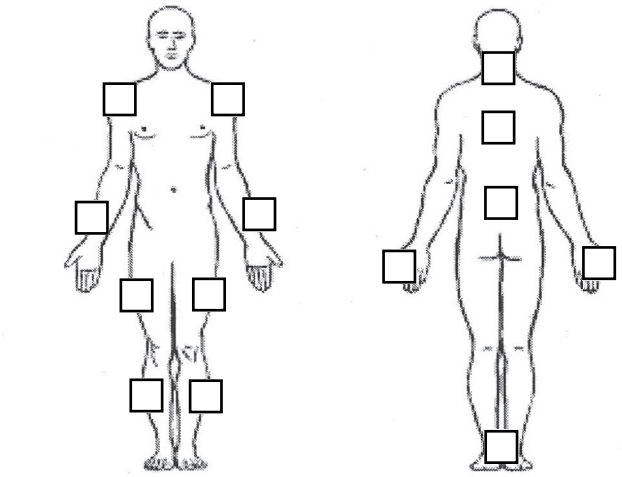
When did the symptoms appear?_____

(i.e. days, weeks, months, years?)

Is this condition getting progressively worse?

☐ Yes ☐ No ☐ Unknown

Please mark an X on the diagram below where you are feeling pain, stiffness, numbness or tingling.



Rate your pain severity on a scale of 1-10

Area:_____Pain rating_____/10

Area:_____Pain rating_____/10

Type of pain: ☐ Stiff ☐ Sharp ☐ Shooting

☐ Dull ☐ Achy ☐ Burning

☐ Numb/Tingling? If yes, where_____

How often do you have this pain (daily, weekly, monthly, etc)_____

Is the pain ☐ constant or ☐ come and go?

Does the pain interfere with your: (check box)

☐ Work ☐ Sleep ☐ Daily Routine ☐ Exercise

Activities or movements which hurt: ☐ Laying down

☐ Sitting ☐ Standing ☐ Walking ☐ Bending

Health History

Height____' ____" Weight_____lbs

What treatments have you already received for your condition?

☐ Medications ☐Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other_____

Name and city of Primary care doctor_____

Name and city of other doctor(s) providers who have treated you for your condition_____

Date of last: Physical exam____/____/_____Spinal Exam____/____/_____ Spinal X-ray____/____/_____

MRI/CT scan____/____/_____ Blood Test____/____/_____

What, if anything has helped with the pain? ☐Rest ☐Ice ☐Heat ☐Pain medication ☐Stretching

What, if anything has made the pain worse? ☐Driving ☐Walking ☐Working ☐Bending ☐Exercise

History of Present Injury/Illness:

Please check boxes indicating current or past symptoms

☐ Neck pain/stiffness	☐Numbness/tingling in Arms	☐Sudden Weight Loss	☐ Nausea
☐ Back pain/stiffness	☐Numbness/tingling in Legs	☐Depression	☐ Loss of taste
☐ Arm/hand pain	☐Fatigue	☐Cold feet	☐ Nervousness
☐ Leg/knee pain	☐Loss of memory	☐Chest pain	☐ Sleeping difficulties
☐ Tension	☐Jaw Problems	☐Fever	☐ Loss of smell
☐ Headaches	☐Cold/night sweats	☐Constipation	☐ Fainting
☐ Stomach problems	☐Shortness of breath	☐Blurred Vision	☐ Night pain
☐ Dizziness	☐Asthma	☐Light sensitivity	☐ Bowel/bladder changes
☐ Sinus Issues	☐Allergies	☐Food sensitivity	☐ Arthritis- where_____
☐ Varicose Veins			

List others/comments:_____ *blank boxes are considered negative.

Past Medical History:

Please check boxes indicating current or past illnesses

☐ High blood pressure	☐ Heart Disease	☐ Migraines	☐ Liver Disease	☐ Rheumatoid arthritis
☐ Diabetes	☐ Pinched nerve	☐ Ulcers	☐ Fibromyalgia	☐ Cancer- if yes where_____
☐ Kidney Disease	☐ High cholesterol	☐ Stroke	☐ Arthritis	☐ Herniated disc
☐ Bleeding disorders	☐ Osteoporosis	☐ Pacemaker	☐ TMJ Issues	☐ Thyroid problems

List others/comments:_____

Injuries/surgeries you have had	Description	Date
Falls	_____	____/____/_____
Head Injury	_____	____/____/_____
Broken bones	_____	____/____/_____
Dislocations	_____	____/____/_____
Surgeries	_____	____/____/_____

Please mark in each column which boxes best describes your activities:

EXERCISE: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

HABITS: ☐ Smoking-Packs/day_____ Alcohol-drinks/week_____

☐ Coffee/Caffeine-cups/day_____High stress level—cause?_____

Medications with dosage and frequency_____

_____

Pain medications tried and outcome? ☐ Advil ☐ Aleve ☐ Tylenol ☐ Steroids ☐ Other (check)

Duration of use? ☐ 0-3 months ☐ 3-6 months ☐ 6+ months

Did the medications? ☐ Heal the injury/pain OR ☐ Mask the pain (check one)

Supplements (vitamins, minerals, herbs)_____

Please list all allergies and reaction_____

Family History- Aside from your personal history, please tell us any conditions that run in your family, along with the family member.

☐ Heart disease_____ ☐ Diabetes_____ ☐ Cancer_____

☐ Arthritis_____ ☐ Stroke_____ ☐ High blood pressure_____

☐ Other_____*All blanks will be considered negative.

The above information on pages 1-3 were filled out to the best of my knowledge.

Signature_____ Date____/____/_____

Thank you for your patience filling out our intake paperwork and questionnaire so we can be well- informed and offer the best care possible for you and your family.

Informed Consent for Care

I, as a patient coming to the doctor, give him/her permission and consent to care for myself in accordance with the appropriate testing, diagnosis, and treatment. The clinical procedures in this office are typically beneficial and rarely cause problems. However, although rare, medical treatment, chiropractic, and physical therapy all carry a small risk with treatment, including but not limited to: fractures, disc injuries, stroke, and sprains.

I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, are in my best interest. We use all precautions (exams, X-rays) and gentle treatment procedures to mitigate any risk.

This office does not perform breast, pelvic, prostate, rectal or full skin evaluations. These examinations should

be performed by your family physician, GYN, or dermatologist to exclude cancers, abnormal skin lesion, or other conditions discovered by routine screenings, This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber ans any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history illnesses, medications, or allergies.

I have read or have read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with San Pedro Chiropractic Clinic to perform treatment procedures and protocols. I intend for this consent to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

_____ _____/_____/_____

Patient name (Print) Date

_____ _____/_____/_____

Patient or Guardian's Signature Date

Acknowledgment of Receipt of San Pedro Chiropractic Clinic Notice of Privacy Policy

By signing this document, I acknowledge that I have received/read a copy of San Pedro Chiropractic Clinic's Notice of Privacy Practices. I also acknowledge that I can request a copy of the Privacy Policy at any time as well as read the ones which is posted in the office.

_____ _____/_____/_____

Patient name (Print) Date

_____

Patient or Guardian's signature