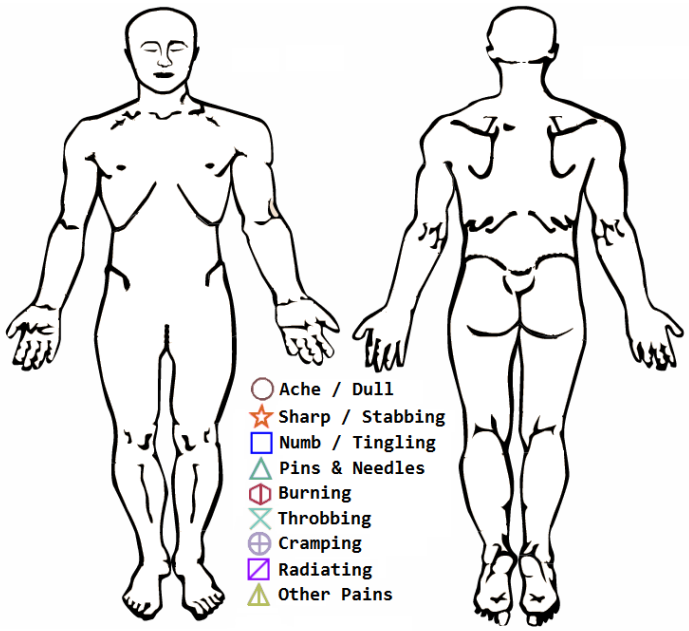
Chiropractic Health & Wellness Center, a place for healing.
323-656-4194

PLEASE NOTE, THIS FORM CANNOT BE SUBMITTED BY A MOBILE DEVICE OR TABLET

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	◯ Male ◯ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Patient Symptoms:



Reason for this Visit:

Describe the reason for this visit?

Please briefly describe, including the impact it has had on your life.

○ Wellness ○ Sports ○ Auto ○ Fall ○ Home Injury ○ Job ○ Chronic Discomfort ○ Other

Briefly Explain: _____

When did this concern begin? _____ Has this concern: ○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ○ Yes ○ No

Briefly Explain: _____

Have you seen other doctor's for this concern? ○ Yes ○ No Doctor's name: _____

Type of Treatment: _____

Results: ○ Good ○ Bad ○ Indifferent

Complaint Information:

Injury Occurred: ○ Work ○ Automobile ○ Third-Party ○ Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Interfere w/ Activities: ○ Yes ○ No Affected Sleep: ○ Yes ○ No Frequency: _____

Missed Work: ○ Yes ○ No Unable to Work from: _____ Unable to Work Until: _____

Affected Appetite: ○ Yes ○ No Explain: _____

Reduced Work: ○ Yes ○ No Explain: _____

Does it Worsen: ○ Yes ○ No Explain: _____

Weather Affects it: ○ Yes ○ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ○ Yes ○ No Explain: _____

X-rays Taken: ○ Yes ○ No Explain: _____

Pain level Rating - Scale 1 to 10: At its best: ____ At its Worst: ____ Current Level: ____

Same Condition Before: ○ Yes ○ No Date: _____ Practitioner: _____

For Women Only:

Are you pregnant? ○ Yes ○ No Are you taking birth control? ○ Yes ○ No Do you take HRT? ○ Yes ○ No

Are you nursing? ○ Yes ○ No Do you experience painful periods? ○ Yes ○ No Do you have irregular cycles? ○ Yes ○ No

Do you perform a regular self breast examination? ○ Yes ○ No Do you have breast implants? ○ Yes ○ No

Do you take oral contraceptives? ○ Yes ○ No

Date of last PAP/pelvic exam? _____ Date of last mammogram? _____ Date of Last Menstrual Period? _____

Personal Health History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ◯ Yes ◯ No Date: _____ Condition(s) treated: _____

Chance Pregnant: ◯ Yes ◯ No Planning: ◯ Yes ◯ No

Medications: _____

Supplements: _____

Personal Incident History:

Broken Bones: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Sprains/Strains: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Hospitalized: ◯ Yes ◯ No Explain: _____

Surgery: ◯ Yes ◯ No Explain: _____

Auto Accident: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Struck Unconscious: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Eating Disorder: ◯ Yes ◯ No Explain: _____

Stroke: ◯ Yes ◯ No Explain: _____

Health Checklist:

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Back Pain
- [ ] Bleeding Disorders
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Cataracts
- [ ] Chest Pain
- [ ] CHF
- [ ] Cold Extremities
- [ ] Constipation
- [ ] COPD/emphysema
- [ ] Cramps
- [ ] CVA (stroke/TIA)
- [ ] Dementia/Alzheimer's
- [ ] Depression
- [ ] Diabetes
- [ ] Diagnosed emotional/mental
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Gallbladder disease/stones
- [ ] Glaucoma
- [ ] Gout
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Menstrual Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Liver disease/cirrhosis
- [ ] Loss of Balance
- [ ] Loss of Memory
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Lung disease
- [ ] Macular Degeneration
- [ ] Migraines
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Parkinson's
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Retinal Disease
- [ ] Sciatica
- [ ] Seizures
- [ ] Shortness of Breath
- [ ] Sinus Infection
- [ ] Skin Sensitivity
- [ ] Sleep Problems/Insomnia
- [ ] Smoked
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other

_____

Have you had any of these Cardiovascular Diseases? Please select all that apply.

- [ ] Myocardial infarction
- [ ] Hypertension
- [ ] Hypercholesterolemia
- [ ] Bypass surgery
- [ ] Coronary artery disease

Do you have Diabetes? If so what type?

○ Type I ○ Type II ○ Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

- [ ] Ulcers
- [ ] Reflux
- [ ] IBS

Family Health History:

Family Health History

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date: _____