# La Jolla Chiropractic Health Center

-CONFIDENTIAL PATIENT INFORMATION FORM-

Name [Mr., Mrs., Ms., Dr.] ____________________________________Date________ E-mail__________________
Address________________________________________City_____________________State_____Zip___________
Home Phone (      )_________________Cell Phone (      )_________________ Birthdate____________ Age_____
Employer______________________Occupation______________________ Work Phone (     )____________
Marital Status: M S W D How many children:_______ Soc. Sec. No. ___ ___ ___-___ ___-___ ___ ___ ___
Name of spouse____________________________________Spouse's Occupation_____________________________
Spouse's employer________________________________________Spouse's Work Phone(      )__________________
Patient's nearest relative______________________________Relationship_____________Phone(      )____________
Referred by_______________________________Date symptoms appeared or accident happened_________________
Is condition due to injury or illness arising from your employment? [] Yes [] No
If so, did you report this condition to your work supervisor? [] Yes [] No Number of days lost from work _____
Has the patient ever had the same or similar condition? [] Yes [] No If Yes, describe _______________________
_____________________________________________________________________________________________
Date of last physical examination______________Reason?_______________________________________________
Doctor's name________________________________What was the diagnosis?________________________________
**Females**: Is there a chance that you could be pregnant? [] Yes [] No Date of last normal menstrual period:_______
What operations have you had, include age at time?__________________________________________________
_____________________________________________________________________________________________
What medical illnesses have you had, include age at time of illness?_______________________________________
_____________________________________________________________________________________________
Previous history of accidents or injuries for which you sought treatment, include age at time?__________________
_____________________________________________________________________________________________
Have you ever been under chiropractic care? [] Yes [] No Reason:_________________________________________
Previous chiropractor?________________________Frequency (Times/Mo)____Date of last treatment?___________

Have you ever suffered from any of the following: **N=I** have it **Now** **P=I** had it in the **Past** **F**= **Family** History

| N P F | N P F | N P F | N P F |
|---|---|---|---|
| [] [] [] A.I.D.S. | [] [] [] Poor postural habits | [] [] [] Tuberculosis | [] [] [] Loss of consciousness |
| [] [] [] Allergy | [] [] [] Sciatica | [] [] [] Bruise easily | [] [] [] Paralysis |
| [] [] [] Head injury | [] [] [] Spinal curvatures | [] [] [] Bed-wetting | [] [] [] Bladder/Urination |
| [] [] [] Headaches | [] [] [] Swollen joints | [] [] [] Nosebleeds | [] [] [] Kidney problems |
| [] [] [] Fatigue/loss of sleep | [] [] [] Colon trouble | [] [] [] Sinus infections | [] [] [] Prostate trouble |
| [] [] [] Ulcers | [] [] [] High blood pressure | [] [] [] Diarrhea | [] [] [] Hepatitis |
| [] [] [] Anxiety | [] [] [] Low blood pressure | [] [] [] Cramps | [] [] [] Difficult digestion |
| [] [] [] Depression | [] [] [] Liver problems | [] [] [] Jaundice | [] [] [] Flatulence or belching |
| [] [] [] Numbness | [] [] [] Hemorrhoids | [] [] [] Chest pains | [] [] [] Breast/Gynecolg. prob. |
| [] [] [] Heart problems | [] [] [] Rapid heart beat | [] [] [] Hot flashes | [] [] [] Itching |
| [] [] [] Cancer/Lymphoma | [] [] [] Abnormal heart beat | [] [] [] Anemia | [] [] [] Fevers/rheumatic fever |
| [] [] [] Arthritis | [] [] [] Low back pain | [] [] [] Low blood sugar | [] [] [] Thyroid problems |
| [] [] [] Circulation | [] [] [] Mid-back pain | [] [] [] Arm/hand problems | [] [] [] Leg/foot problems |
| [] [] [] Stroke/T.I.A.s | [] [] [] Neck pain | [] [] [] Coughing | [] [] [] Varicose veins |
| [] [] [] Diabetes | [] [] [] Rapid weight change | [] [] [] Asthma | [] [] [] Swelling of ankles |
| [] [] [] Bursitis | [] [] [] Venereal Diseases | [] [] [] Memory loss | [] [] [] Lung problems |
| [] [] [] Eating disorders | [] [] [] Weakness | [] [] [] Eye/vision problems | [] [] [] Ear/hearing problems |
| [] [] [] Infection | [] [] [] Inflammation | [] [] [] Swelling | [] [] [] Poor Circulation |

Have you ever had tingling, shooting pains, or numbness in any of the following areas:

| Now | Past | | Now | Past | |
|---|---|---|---|---|---|
| [] | [] | Shoulders | [] | [] | Hips |
| [] | [] | Arms | [] | [] | Thighs |
| [] | [] | Elbows/wrists | [] | [] | Legs/ankles |
| [] | [] | Hands | [] | [] | Feet |

| | Yes | No |
|---|---|---|
| Do you take vitamin or mineral supplements? | [] | [] |
| Do you think you may need supplements? | [] | [] |

HABITS: **H**=Heavy **M**=Moderate **L**=Light **N**=None **P**=Past

| | H | M | L | N | P | |
|---|---|---|---|---|---|---|
| Alcohol | [] | [] | [] | [] | [] | |
| Caffeine | [] | [] | [] | [] | [] | |
| Tobacco | [] | [] | [] | [] | [] | Pk-Years ___ |
| Drugs | [] | [] | [] | [] | [] | |
| Appetite | [] | [] | [] | [] | [] | |
| Exercise | [] | [] | [] | [] | [] | |
| Sleep | [] | [] | [] | [] | [] | |

**Do you ever sleep on your stomach? Yes [ ] No [ ]**

Do you wear or use any type of corrective supports for your...
[] Neck [] Back [] Shoulders, Elbows, Wrists [] Knees, Ankles, Feet [] Teeth/Jaws, **Pillow Type?** ____________

Purpose of this appointment? (Describe your major complaints)____________________________________________

__________________________________________________________________________________________

What activities aggravate your condition?__________________________________________________________
What do you do to help your condition?___________________________________________________________
Is this condition getting worse? [] Yes [] No Is it more [] Constant …or does it [] Come and Go?
Is this condition interfering with your: [] Work [] Sleep [] Daily routine [] Other____________________________
What do you believe is wrong with you?___________________________________________________________
List other doctors seen for this condition?_________________________________________________________
Have you ever had any of these studies? [ ] X-rays [ ] MRI [ ] CT Scan [ ] Other _________ Dates?___________
Have you been treated for any health conditions by a physician in the last year? [] Yes [] No
If yes, please describe:__________________________________________________________________________
What medications or drugs are you taking?_________________________________________________________

__________________________________________________________________________________________

Do you have any allergies or adverse reactions to any drugs? Please describe: ________________________________
Has there been any significant stress recently in your life? ______________________________________________
Can you attribute your condition to any possible changes in exercise, work, leisure, or sleep habits? ______________

__________________________________________________________________________________________

**PAYMENT IS EXPECTED AT TIME OF EACH VISIT...**

Name of person responsible for payment___________________________________________________________

Relationship to Patient _____________Is Patient insured? [] Yes [] No Company_____________________________

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare itemized billings to assist me in making collections from my insurance company, so **I give a General Release for this office to provide my insurance company any necessary medical information to process my claim**. However, I understand that all charges for health services rendered to me are my responsibility, and will be paid by me at the time I receive treatment. **Note**: For changes or cancellations of appointments, a **48 business-hour** advance notice is required to avoid possible full charges (e.g., for a 9:00 a.m. Monday appointment, please cancel by 9:00 a.m. Thursday, the week before).

Signature of Person responsible for Payment ________________________________________Date_____________

To allow for payment by check or credit card, please also include the following information:

Driver's License #__________________________________ State___________ Credit Card Type: Visa / MasterCard
Credit Card #________________________________________________Expiration Date________________________
Name Exactly As It Appears on Your Card_________________________________________________________
Card Billing Address________________________________________________________________Zip____________

FOR OFFICE USE ONLY...

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If you have any questions or concerns or problems at any time, please feel free to contact the doctor's voice mail at (619) 687-7676. For emergencies, the doctor's cell phone number is (858) 472-1857. He will make every effort to return your call as soon as possible.

The integrity of your physical, emotional, and spiritual health is the doctor's primary concern, and you will witness this commitment in the energy and effort he dedicates to each session with you. The doctor extends you a ***warm welcome***, and promises to offer you an ever-new and powerful opportunity for Depth Healing!