Chiropractic Solutions

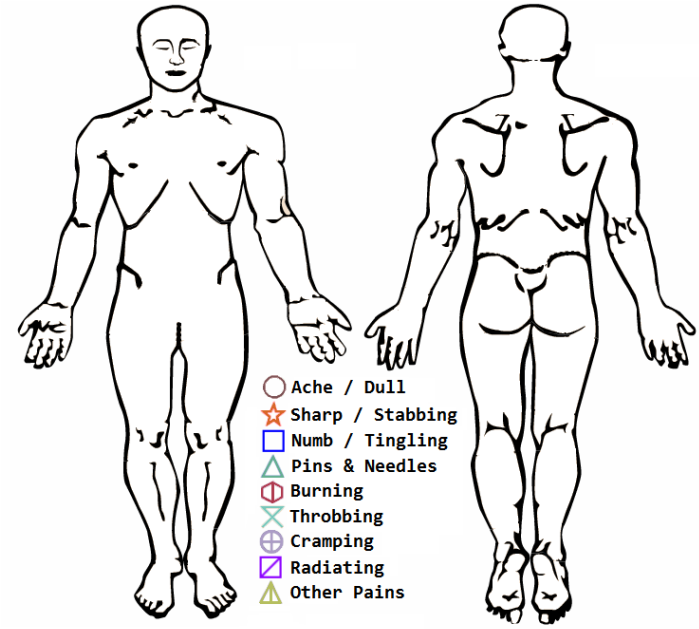
1885 Winchester Blvd , Campbell, CA 95008

Phone: 408-370-2190

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:



Patient Social

Alcohol:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Caffeine:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Drugs:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Exercise:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never
Homemade Food:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Processed:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Tobacco:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never					

Referral Information:

Referring Physician: _____ Referred Patient: _____ Referred by _____

Advertisement: ◯ Yes ◯ No Advertisement: _____

Referred Directory: ◯ Yes ◯ No Referred Directory: _____

Employer Information:

Employed: _____ Employer Name _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

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: _____

Insurance Information:

Payment Name _____ Primary Phone # _____ Primary ID/Policy _____

Payment Address _____

Payment City _____ Payment State _____ Payment Zip _____

Primary Group # _____ Primary Name _____ Primary DOB _____

Secondary Name _____ Secondary Phone # _____ Secondary ID/Policy _____

Secondary Address _____

Secondary City _____ Secondary State _____ Secondary Zip _____

Secondary Group # _____ Secondary Name _____ Secondary DOB _____

Claim # _____ Claim Contact _____ Claim # _____

Attorney Name _____ Attorney Phone # _____

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ I want the Doctor to select the type of care appropriate for my condition
- ☐ Relief care: Symptomatic relief of pain or discomfort.
- ☐ Corrective care: Correcting and relieving the cause of the problem as well as the symptom
- ☐ Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

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

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: _____