WEST HILLS CHIROPRACTIC GROUP

Please fill out the following form in as much detail as possible.

Please print

Date ___________________

Name ____

Address ____

City ___________________________________ State _____________ Zip ________

Home Phone ____________________________ Office Phone __________________

E-mail Address ____

Age _______ Date of Birth __________ Occupation ____________ Sex (M) (F)

Weight ______________ Referred by ____

Employer __________________________ Address _____________________________

Married ___ S ___ W ___ D ___ Children____ Name of Spouse ___________________

Is any other member of your family being treated in this office? ____________________

Have you ever had chiropractic care before? _____________________________________

For what problem? ____

Were the results satisfactory? Yes______ No_______ N/A_______

Major complaints and symptoms — please be as specific as you can. Ask the doctor or nurse for help if you need assistance in filling out this section. ______________________

____

____

____

How do you believe your problem (pain) began? ________________________________

____

____

____

____

When did you first notice this problem/pain? ___________________________________

Have you lost any work? ____________ Day and date you last worked _____________

Have you ever had this condition before or a similar condition? ____________________

When?
____

What positions or activities aggravate your condition? ____________________________

What positions or activities relieve your condition? ______________________________

Have you ever been treated by a Medical Physician for this ailment?_________________

Where?
____

Describe the type of treatment ____

Diagnosis of previous physician ____

Length of time under care_______________________ Results ____________________

Family physician's name ____
Please send a report to my family physician. Yes____ No ____

Will this case be covered by any insurance company? Major Medical _____ Auto ______
Blue Cross/Blue Shield ____ Workers' Compensation ____ Medicare _____ Other _____

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc.
(even as a child)?_______________ When? ____________________________________

Are you allergic to anything you are aware of? __________________________________

Are you presently taking any medication, herbs, or over the counter products
(aspirin included)? Yes_______ No________
If yes, name them ____

Have you ever broken any bones? (fractures) ___________ Any dislocations? ________

What operations have you had? ____________________Year _________________
____________________Year _________________
____________________Year _________________

Have you had any surgery to replace hip, knee, etc.? ___________Year _____________
Give dates you have had any of the following? (if exact date is unknown, give approximate)

Blood tests _________________________ Urinalysis ______________________________

MRI _______________ CT Scan ________________ Ultrasound __________________

Radiation Treatment ___________________ X-Ray examination __________________

Other special treatment ____

At what hospital or office were these tests taken _________________________________

Name of doctor who ordered tests ____

Do you have any reason to believe that you may be pregnant? Yes ______ No_______

Do you have any health problems not listed above? _______________________________

Do you faint easily? ____

Do you take vitamins? Yes______ No ______ If yes, please list them _______________

Do you exercise regularly? Yes ________ No ________ What kind of exercise? _______

____

Habits: (please check)

Cigarettes ________ Quantity ___________Coffee? ________ Quantity ____________

Alcohol? ________ Quantity ___________ Tea? ________ Quantity _______________

Hobbies ____

Have you been treated for any health condition by a physician in the past year? _______
If yes, what condition? ____

Have you lost or gained weight in the past year? _________________________________

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now N	**Past P**		**Now N**	**Past P**
Headaches____ Frequency	____	____	Loss of Balance	____	____
Neck Pain	____	____	Fainting	____	____
Stiff Neck	____	____	Loss of Smell	____	____
Sleeping Problems	____	____	Loss of Taste	____	____
Back Pain	____	____	Diarrhea	____	____
Nervousness	____	____	Feet Cold	____	____
Tension	____	____	Hands Cold	____	____
Irritability	____	____	Arthritis	____	____
Chest Pains	____	____	Muscle Spasms	____	____
Dizziness	____	____	Frequent Colds	____	____
Shoulder/Neck/Arm Pain	____	____	Stomach Upset	____	____
Pins & Needles in Arms	____	____	Constipation	____	____
Pins & Needles in Legs	____	____	Cold Sweats	____	____
Numbness in Fingers	____	____	Fever	____	____
Numbness in Toes	____	____	Sinus Problems	____	____
High Blood Pressure	____	____	Diabetes	____	____
Difficulty Urinating	____	____	Hemorrhoids	____	____
Allergies	____	____	Leg Cramps	____	____
Weakness in Arms	____	____	Colitis	____	____
Weakness in Legs	____	____	Gall Bladder	____	____
Shortness of Breath	____	____	Indigestion	____	____
Fatigue		____ ____	Belching		____
____					
Depression	____	____	Vomiting	____	____
Lights Bother Eye	____	____	Shoulder Pain	____	____
Loss of Memory	____	____	Swelling Joints	____	____
Ears Ring	____	____	Knee Pain	____	____
Face Flushed	____	____	Hayfever	____	____
Buzzing in Ears	____	____	Menstrual Difficulties	____	____

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE ____