CHIRO-HEALTH

211 Sutter St. Suite 401 San Francisco, CA 94108 Tel. (415) 546-1461

PATIENT INFORMATION

Date: ____________

E-mail: ____________

Name: ____________

Address: ____________

City State Zip

Sex: ☐ M ☐ F Age: ______ Birth Date: ____________

Patient SS# ____________

Occupation: ____________

Employer: ____________

Employer Address: ____________

Employer Phone: ____________ ext.

Referral Source: ____________

INSURANCE INFORMATION

Who is responsible for this account: ____________

Relationship to Patient: ____________

Insurance Company: ____________

Group # ____________

Member # ____________

Is Patient covered by additional insurance: ☐ Yes ☐ No

Subscriber Name: ____________

Birth Date: ______ SS# ____________

Relationship to Patient: ____________

Insurance Company: ____________

Group # ____________

Member # ____________

CONTACT INFORMATION

Home Phone: ____________

Work Phone: ____________ ext.

Mobile Phone: ____________

Best time and place to reach you: ____________

IN CASE OF EMERGENCY, CONTACT:

Name: ____________ Relationship: ____________

Phone: ____________

ACCIDENT INFORMATION

Is condition due to accident? ☐ Yes ☐ No Date: ____________

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable): ____________

Attorney Phone: ____________ ext.

May we contact your Attorney? ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________ and assign directly to Dr. ____________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Name: ____________ Signature: ____________ Date: ____________

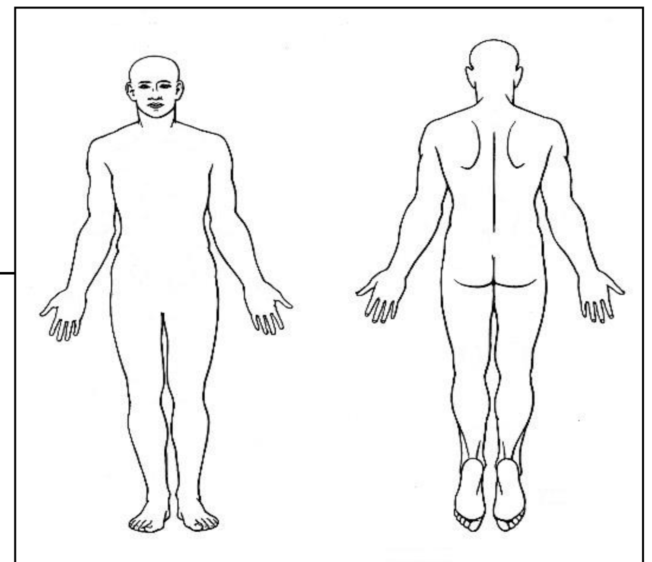
PATIENT CONDITION

Reason for Visit: ____________

When did your symptoms appear? ____________

Is this condition getting progressively worse? ☐ YES ☐ NO ☐ UNKNOWN

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): ______

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ____________

Is it constant or does it come and go? ____________

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Lying on side

HEALTH HISTORY — Patient Name

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other (specify): ____________

DOCTOR(S) WHO HAVE TREATED YOU FOR YOUR CONDITION:

Name: ____________ Address: ____________ Phone: ____________

Date of Last:					
Physical Exam	________	Spinal X-Ray	________	Blood Test	________
Spinal Exam	________	Chest X-Ray	________	Urine Test	________
Dental X-Ray	________	MRI / CT-Scan / Bone Scan			________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
AIDS / HIV	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Other: ________	
Glaucoma	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	________	

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason ________

Are you pregnant? ☐ Yes ☐ No Due Date: / / (mm/dd/yy)

Past Injuries/Surgeries:		Description	Date (mm/dd/yy)
Falls	☐ Yes ☐ No		/ /
Head Injuries	☐ Yes ☐ No		/ /
Broken Bones	☐ Yes ☐ No		/ /
Dislocations	☐ Yes ☐ No		/ /
Surgeries	☐ Yes ☐ No		/ /

MEDICATIONS	VITAMINGS/HERBS/MINERALS	ALLERGIES
Pharmacy Name:		