(925) 292-5850

Patient Information

Name: _____ SSN:_____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail _____ Sex: ▫ M o F Marital Status: _____ No. Children _____

Who is responsible for your bill: o Self o Personal Ins. o Work Comp o Parent oAuto Ins. o MC

Referred to this office by:

_____

Employment Information

Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Emergency Information

Name of Emergency Contact: _____ Phone: _____

Relationship to Patient:_____

Current Health Condition

Chief Complaint: _____

When did the condition begin: _____

Can you perform your regular work duties: o Yes o No

Is your condition due to an accident? o Yes o No Illness? o Yes o No Other: _____

Did your accident occur at work? o Yes o No Date of Accident: _____

Were you involved in an automobile accident? o Yes o No Date of Accident: _____

Do you have any drug allergies? o Yes o No If yes, what? _____

Are you currently on any medications: o Yes o No If so, what: _____

Past Health History

Please report any past health conditions that may affect a proper diagnosis.

Major Surgeries or Operations: o Yes o No If yes, explain: _____

Broken Bones: o Yes o No Major falls or accidents: o Yes o No Hospitalizations: o Yes o No

Describe your most recent medical Treatment: _____

Previous Chiropractic care: o Yes o No Name of Doctor: _____

List any Hobbies, Sports and Activities: _____

Review of Systems *(Check all that apply)*

Diseases
o Heart Disease
o Cancer
o Polio
o Tuberculosis
o Anemia
o Chicken Pox
o Diabetes
o Epilepsy
o MS
o Parkinson's
o Allergies

Genitourinary
o Bladder trouble
o Painful Urination
o Excessive Urination
o Discolored Urine

Male/Female
o Menstrual problems
o Breast lumps
o Prostate problems

Musculoskeletal
o Low Back Pain
o Mid-back pain
o Neck Pain
o Arm Pain
o Leg Pain
o Joint Pain or Stiffness
o Difficulty walking
o Clicking or painful jaw

Nervous System
o Numbness
o Paralysis
o Dizziness/Vertigo
o Forgetfulness
o Confusion
o Depression
o Fainting
o Convulsions
o Cold/Tingling Extremities

Gastro-intestinal
o Excessive thirst
o Nausea
o Vomiting
o Diarrhea
o Constipation
o Weight problems
o Abdominal cramps
o Gas or bloating
o Heartburn

Cardiovascular
o Chest Pain
o Shortness of breath
o High blood pressure
o Irregular heartbeat
o Lung problems
o Ankle swelling
o Heart problems

EENT
o Vision Problems
o Hearing Problems

Females Only
When was your last period? _____ Is there a possibility that you might be pregnant? ☐Yes ☐No

Consent for Treatment and Insurance Authorization

I hereby authorize the release of information to my insurance company concerning the charges and treatment provided to me by the Doctor of Chiropractic at In Motion Sports and Family Chiropractic. I hereby assign benefits and I understand that payment is due as services are provided, including my deductible, co-payment, coinsurance, or any balance not paid by my insurance company (excluding contractual allowance). If, after 60 days, insurance payment has not been received, I understand that the charges are my responsibility and payable immediately. Additionally, I consent to treatment as deemed necessary by the Doctor of Chiropractic at In Motion Sports and Family Chiropractic.

Patient Signature: _____ Date: _____