· Est. 1990 ·
CARLSBAD
CHIROPRACTIC
· 760.720.2273 ·

INITIAL HEALTH STATUS

Patient Name _____ **Social Security #** _____

Address _____ **City** _____

State ____ **Zip**_____ **Home Phone ( )** _____ **Cell Phone ( )** _____

Cell Carrier_____ **Email Address**_____

Birthdate_____ **Sex: M / F** **Employer**_____

Occupation_____ **Work Phone ( )** _____

Address_____ **City** _____

State _____ **Zip** _____ **Referral Source (Personal/Insurance/Online search)**_____

Emergency Contact Name and Number _____

Marital Status: ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** **# of Children**_____

Spouse Name _____ **Spouse Employer**_____

Address_____ **City**_____ **State**____ **Zip**_____

Primary Care Physician Name_____ **PCP Phone ( )**_____

Payment Information:

Subscriber Name_____ **Health Plan**_____

Subscriber ID #_____ **Group #** _____

I clearly understand and agree that all of the services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable

I also agree to pay any collection fees associated with my bill incurred at this office.

Patient Signature:_____ **Date:** _____

Height_____ **Weight** _____ **Age** _____

What is your major complaint?_____

Date Problem Began_____

How Problem Began_____

Is this condition getting progressively worse? ☐ **Yes** ☐ **No** ☐ **Constant** ☐ **Comes & Goes**

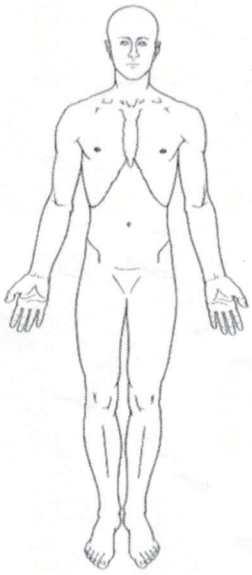
Have you had a similar condition in the past?_____

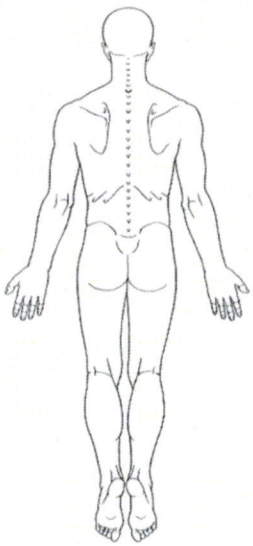
How long has it been since you felt really good (no pain)? _____

Mark an X on the picture where you have pain or other symptoms.

Numbness = N **Tingling = T** **Dull Pain = D**

Sharp Pain = P **Burning = B** **Stiffness = S**





Right **Left** **Left** **Right**

Current complaint (how you feel today):

No Pain - 0 1 2 3 4 5 6 8 9 10 –Unbearable Pain

How often are your symptoms present?

(Occasional) ☐ **0 – 25%** ☐ **26 – 50%** ☐ **51 – 75%** ☐ **76 – 100% (Constant)**

Patient Name_____ **Date** _____

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had spinal X-Rays, MRI, C.T. Scan or any other testing for your area(s) of complaint?
☐ No ☐ Yes

Date(s) taken _____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence

☐ Recent Fever

☐ Diabetes

☐ High Blood Pressure

☐ Stroke (Date) _____

☐ Corticosteroid Use (Cortisone, Prednisone,etc.)

☐ Taking Birth Control Pills

☐ Dizziness/Fainting

☐ Numbness in Groin/Buttocks

☐ Cancer/Tumor (Explain)_____

_____

☐ Osteoporosis

☐ Epilepsy/Seizures

☐ Prostate Problems

☐ Menstrual Problems

☐ Urinary Problems

☐ Currently Pregnant, # Weeks _____

☐ Abnormal Weight Gain Loss

☐ Marked Morning Pain/Stiffness

☐ Pain Unrelieved by Position or Rest

☐ Pain at Night

☐ Visual Disturbances

☐ Tobacco Use – Type _____

Frequency_____

☐ Rheumatoid Arthritis

☐ Other - Please Describe_____

Surgeries_____

Current Medications_____

Other Health Problems/Injuries (Explain) _____

_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke

☐ Other_____

Patient Name _____ **Date** _____

SYMPTOM SURVEY

1. GENERAL SYMPTOMS: (Circle as many as apply)

A) Nervousness
B) Irritability
C) Fatigue
D) Depression
E) Loss of sleep
F) Tension
G) PMS
H) Jaw Pain

2. HEAD: (Circle as many as apply)

A) Headache 1) Mild 2) Moderate 3) Severe

How Often (1 2 3 4 5 6 7) Per (Day / Wk/ Mo)

Are they: 1) Sharp 2) Dull

Are they: 1) Constant 2) Intermittent

Where located: 1) Back of Head 2) Forehead 3) Temple
4) Right Side 5) Left Side 6) Behind Eyes

B) Light Headed C) Memory Loss D) Fainting

E) Blurred Vision F) Double Vision G) Sensitivity to Light

H) Loss of Balance I) Hearing Loss J) Ringing in Ears

3. NECK: (Circle as many as apply)

A) Pain 1) Left Side 2) Right Side 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe

Pain Increased by:

1) Forward Movement 2) Backward Movement
3) Rotate Head RT 4) Rotate Head LT
5) Bend Neck RT 6) Bend Neck LT

4. SHOULDERS: (Circle as many as apply)

A) Pain in Joint	1) Left	2) Right	3) Both
B Pain Across Shoulders	1) Left	2) Right	3) Both
C) Limitations	1) Left	2) Right	3) Both
D) Tension	1) Left	2) Right	3) Both

5. ARMS: (Circle as many as apply)

A) Pain in Upper Arms	1) Left	2) Right	3) Both
B) Pain in Elbow	1) Left	2) Right	3) Both
C) Pain in Forearm	1) Left	2) Right	3) Both
D) Pins & Needles (Arm)	1) Left	2) Right	3) Both
E) Pins & Needles (Forearm)	1) Left	2) Right	3) Both
F) Numbness in Arm	1) Left	2) Right	3) Both
G) Numbness in Forearm	1) Left	2) Right	3) Both

6. HANDS: (Circle as many as apply)

A) Pain in Wrist	1) Left	2) Right	3) Both
B) Pain in Hand	1) Left	2) Right	3) Both
C) Pins & Needles	1) Left	2) Right	3) Both
D) Numbness (Hand)	1) Left	2) Right	3) Both

7. UPPER/ MIDBACK: (Circle as many as apply)

A) Pain 1) Left 2) Right 3) Both
Pain level 1) Mild 2) Moderate 3) Severe
Pain type 1) Sharp

10. LOWBACK: (Circle as many as apply)

A) Upper Lumbar Pain	1) Left	2) Right	3) Both
B) Lower Lumbar Pain	1) Left	2) Right	3) Both
C) Sacroiliac Pain	1) Left	2) Right	3) Both
D) Muscle Spasm	1) Left	2) Right	3) Both
Low Back Pain Level	1) Mild	2) Moderate	3) Severe

8. CHEST: (Circle as many as apply)

A) Deep Chest Pain 1) Left 2) Right 3) Both
- Pain Level 1) Mild 2) Moderate 3) Severe
B) Pain Around Ribs 1) Left 2) Right 3) Both

C) Shortness of Breath D) Irregular Heartbeat

9. ABDOMINAL SYMPTOMS: (Circle as many as apply)

A) Pain 1) Mild 2) Moderate 3) Severe

B) Nervous Stomach C) Heartburn D) Gas E) Constipation
F) Diarrhea G) Nausea H) Indigestion I) Loss of Appetite

11. HIPS AND LEGS: (Circle as many as apply)

A) Pain in Buttocks 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe

B) Pain in Hip Joint 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe

C) Pain Down Leg 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
Pain Radiates 1) Knee 2) Calf 3) Foot

D) Numbness Down Leg 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side

E) Pins & Needles (Legs) 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side

F) Knee Pain Leg 1) Left 2) Right 3) Both
G) Leg Cramps 1) Left 2) Right 3) Both

12. FEET: (Circle as many as apply)

A) Ankle Pain	1) Left	2) Right	3) Both
B) Swollen Ankle	1) Left	2) Right	3) Both
C) Foot Pain	1) Left	2) Right	3) Both
D) Numbness of Feet	1) Left	2) Right	3) Both
E) Swollen Feet	1) Left	2) Right	3) Both
F) Cramps	1) Left	2) Right	3) Both

Name _____ Date _____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ **Date** _____