CARLSBAD CHIROPRACTIC CASE HISTORY

Please complete this form in its entirety

Name_____ Social Security#_____

Address_____ City_____ State_____ Zip Code_____

Home phone #_____ Cell Phone #_____Carrier _____

Email Address (used for appt. reminders)_____

How did you hear about us?_____

If you found us on the internet, what did you type in the search field? _____

Date of Birth _____ Age_____ Sex M ☐ F ☐ Height_____ Weight_____

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

# of Children_____ Spouse's Name_____ Spouse's #_____

Employer_____ Occupation_____

Work Address_____City_____ Zip:_____Work phone#_____

Emergency Contact Name and Phone#_____

What is your major complaint? _____

How long have you experienced this condition? _____

Have you had a similar condition in the past? _____

What aggravates your condition? _____

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

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

List all surgical operations _____

Please list all current medications _____

Other doctors seen for this condition: MD ☐ DC ☐ DO ☐ DDS ☐

Doctor's name _____ Diagnosis _____

X Rays or MRI completed? _____ Date _____ Results _____

Payment Information

Are you covered by insurance, Medicare, or will you be paying out of pocket?

_____

Name of insurance company, if applicable _____

Policy# _____ 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's Signature: _____ Date: _____

Carlsbad Chiropractic

2808 Roosevelt Street, Suite 102
Carlsbad, CA 92008
(760) 720-2273 Phone
(760)730-9911 Fax

Date: _____

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with Dr. Gamboa. Necessary forms will be completed to file for insurance payments.

Assignment of Benefits

The patient _____ hereby authorizes any and all insurance companies (including second and third parties), attorney representing said patient, group medical plan, MED-PAY or any individual who has endorsed or co-signed to cover patient medical expense to pay Dr. Desi Gamboa directly for medical services rendered to said patient arising out of injuries suffered on _____

Patient assigns and irrevocably grants a lien against any settlement offer, verdict, or court judgment received by the patient for treatment received in connection with injuries suffered on date mentioned above.

I also authorize the said insurance companies to draft these checks out in the name of:

Dr. Gamboa, D.C., located at:
2808 Roosevelt Street, Suite 102
Carlsbad, CA 92008

Patient understands and accepts full financial responsibility for the services rendered to Dr. Gamboa arising out of this accident; and acknowledges that this obligation cannot be extinguished, modified or change or failure of the patient to be compensated by the individual(s) or parties found and held financially responsible for said injuries.

Full payment of the patient's obligation is not contingent in anyway nor is it dependent on any settlement or judgment which may be agreed to or awarded to the patient.

Patient waives and relinquishes any right which he/she may have to rescind or to seek the rescission of this agreement and further agree that this lien shall be binding upon all of my successors, agents, assigns, and attorneys.

Date _____ Patient's Signature _____

(Mother/Father if minor) Attorney's copy: Please keep a copy for your records. A fax copy of this is considered an original.

Date _____ Attorney Signature _____

SYMPTOM SURVEY

NAME DATE

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
B) Stiffness C) Muscle Spasm D) Grinding/Grating Sounds

4. SHOULDERS: (Circle as many as apply)

A) Pain in Joint	1) Left	2) Right	3) Both
B) Pain Across Shoulder	1) Left	2) Right	3) Both
C) Limitation of Movement	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 Arm	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 (Hand)	1) Left	2) Right	3) Both
D) Numbness (Hand)	1) Left	2) Right	3) Both

7. 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/Stabbing 2) Dull Ache
B) Muscle Spasm 1) Left 2) Right 3) Both

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

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

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 to	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

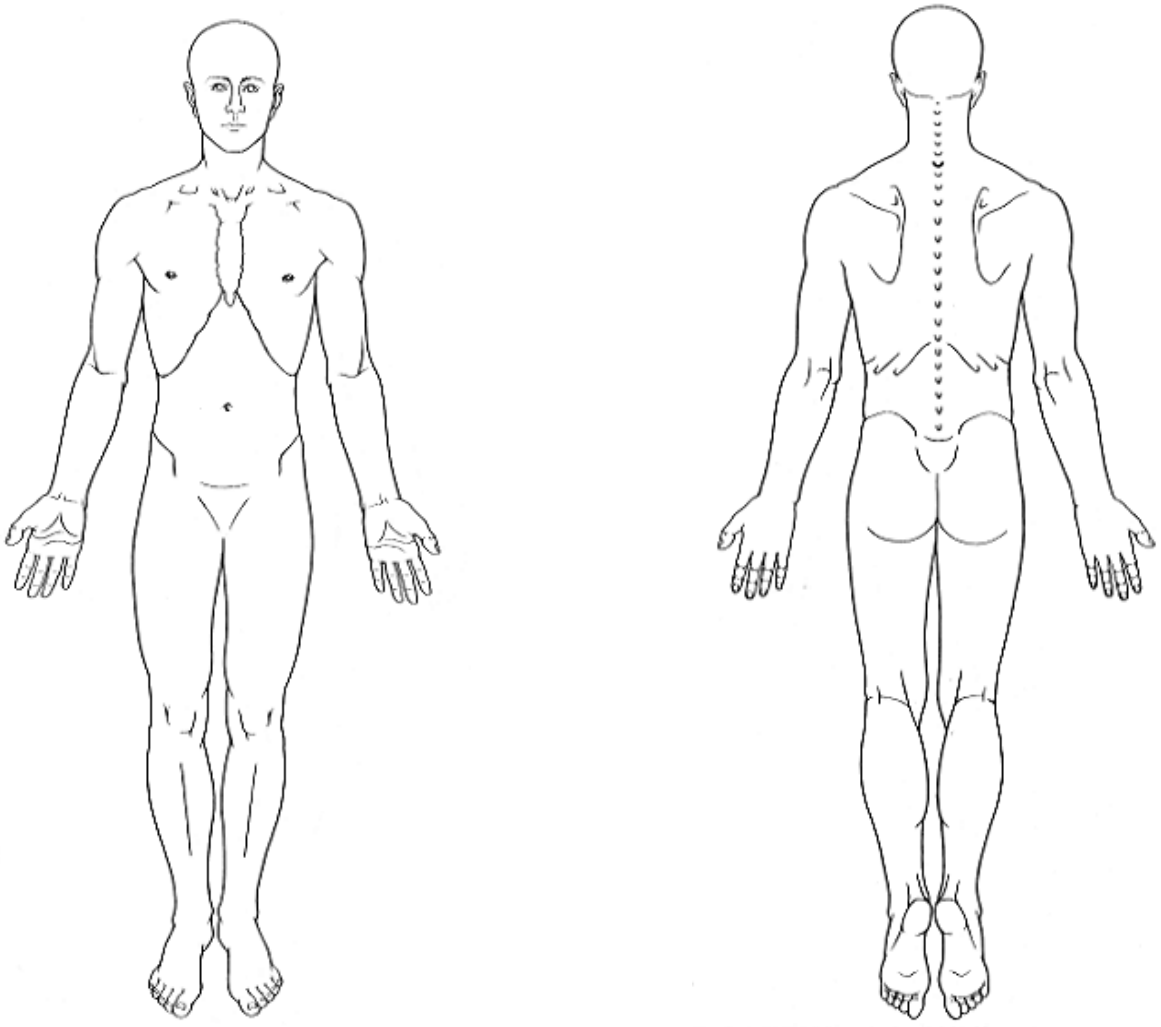
CARLSBAD CHIROPRACTIC

Name _____ Date _____

In the drawing below please indicate where you are experiencing pain by drawing in the letter abbrevation(s) on the diagram that most accurately reflects the type of discomfort that you have been experiencing.

Numbness = N	Tingling = T	Dull Pain = D
Sharp Pain = P	Burning = B	Stiffness = S

Right Left Left Right



GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

NECK Pain and Disability Questionnaire

Rate the severity of your pain by circling one number: (No Pain) 0 . 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10 (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please just check ONE line that best describes your current predicament.

Section 1– Pain Intensity
___ I have no pain at the moment.
___ The pain is very mild at the moment.
___ The pain is moderate at the moment.
___ The pain is fairly severe at the moment.
___ The pain is very severe at the moment.
___ The pain is the worst imaginable at the moment.

Section 2– Personal Care (washing, dressing, etc.)
___ I can look after myself normally without causing extra pain.
___ I can look after myself normally but it causes extra pain.
___ I am slow and careful because it is painful for me to look after myself.
___ I need some help but manage most of my personal care.
___ I need help every day in most aspects of care.
___ I do not get dressed, I wash with difficulty and stay in bed.

Section 3– Lifting
___ I can lift heavy weight without extra pain.
___ I can lift heavy weight but it causes extra pain.
___ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like on a table.
___ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
___ I cannot lift any weight due to neck pain.

Section 4– Reading
___ I can read as much as I want to with no pain in my neck.
___ I can read as much as I want to with slight neck pain.
___ I can read as much as I want to with moderate neck pain.
___ I cannot read as much as I want to due to moderate neck pain.
___ I can hardly read at all because of severe neck pain.

Section 5– Headaches
___ I have no headaches at all.
___ I have slight headaches that occur infrequently.
___ I have moderate headaches that occur infrequently.
___ I have frequent moderate headaches.
___ I have frequent severe headaches.
___ I have severe headaches all the time.

Section 6- Concentration
___ I can concentrate fully when I want to with no difficulty.
___ I can concentrate fully when I want to with slight difficulty.
___ I have a fair degree of difficulty in concentrating when I want to.
___ I have a great deal of difficulty in concentrating when I want to.
___ I cannot concentrate at all.

Section 7- Work
___ I can do as much work as I want to.
___ I can only do my usual work, but no more.
___ I can do most of my usual work, but no more.
___ I cannot do my usual work.
___ I can barely do any work at all.
___ I cannot do any work at all.

Section 8- Driving
___ I can drive my car without any neck pain.
___ I can drive my car as long as I want with slight neck pain.
___ I can drive my car as long as I want with moderate neck pain.
___ I cannot drive my car as long as I want.
___ I can hardly drive at all because of severe neck pain.
___ I cannot drive my car at all.

Section 9- Sleeping
___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hour sleepless)
___ My sleep is mildly disturbed (1 hour sleepless)
___ My sleep is moderately disturbed (2 to 3 hours sleepless)
___ My sleep is greatly disturbed (4 to 5 hours sleepless)
___ My sleep is completely disturbed (6 to 7 hours sleepless)

Section 10- Recreation
___ I am able to engage in all my recreation activities with no neck pain.
___ I am able to engage in all my recreation activities with some neck pain.
___ I am able to engage in most, but not all of my usual recreation activities.
___ I am able to engage in a few of my usual recreation activities.
___ I can hardly do any recreation activities.
___ I cannot do any recreation activities due to neck pain.

Patient Name (Print) _____ Patient Signature _____ Date _____

FOR OFFICE USE ONLY:
_____ x 2 = _____
Total Points Disability Percentage Rating Scale

Carlsbad Chiropractic
2808 Roosevelt Street, Suite 102
Carlsbad, Ca. 92008

Date of accident _____

Insurance information

Your Vehicle insurance
Company_____

Address of your ins.
Company_____

Policy Number _____

Phone Number (_____)_____

Adjuster Name (person handling the claim) _____

Claim Number _____

Other Party involved

Other parties Vehicle insurance Company_____

Address of their ins. Company_____

Policy Number _____

Phone Number (_____)_____

Adjuster Name (person handling the claim) _____

Claim Number _____

AUTOMOBILE ACCIDENT HISTORY FORM

Your Name:_____ Today's Date:_____

Date of Accident:_____ Time of 'accident:_____ a m / p m

City of Accident:_____ Street of accident:_____

Road conditions at the time of the accident: WET DRY ICY OTHER_____

Did the police come to the accident scene? YES NO; Is there a report? YES NO

Did you go to a hospital? YES NO

If yes, what is the name and city of the hospital?_____
How did you get to the hospital?_____
What parts of your body were x-rayed at the hospital?_____
What did the hospital do for your injuries?_____
How long did you stay at the hospital?_____

What bleeding cuts did you sustain during this accident?_____
What bruises did you sustain during this accident?_____

Where were **you** seated in the vehicle?_____

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise? AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO; How long:_____
Do you remember the actual collision? YES NO

Did you experience a flash of light or explosion in your head? YES NO

Did you become CONFUSED DISORIENTED LIGHT HEADED
DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS
from the accident? (please circle)

If you still have any of those symptoms, which ones?_____

Are you currently suffering from any of the following (please circle):

RESTLESSNESS	IRRITABLE
DIFFICULT CONCENTRATING	DIFFICULT WITH MEMORY
SLEEPLESSNESS	FORGETFULNESS
REDUCED TOLERANCE TO HEAT	REDUCED TOLERANCE TO ALCOHOL

What is the approximate distance between the back of your head and your vehicle's headrest? _____inches

Did your head go back over the top of your vehicle's headrest? YES NO

Were you wearing a seatbelt? YES NO
If yes, was it a lap seatbelt _____ shoulder-lap seatbelt _____

Does your vehicle have an airbag? YES NO
Did the airbag deploy in this accident? YES NO
Did you receieve an injury from the airbag? YES NO
Please describe: _____

List the year, make and model of the vehicle you were in:
year _____ make _____ model _____

Was your car stopped at the time of impact? YES NO
If yes, was the driver's foot also on the brake? YES NO
If no, then estimate the speed of the vehicle you were in: _____mph

On what part of the automobile did your following body parts hit?
head hit _____ chest hit _____
right/left shoulder hit _____ right/left arm hit _____
right/left hip hit _____ right/left leg hit _____
right/left knee hit _____ other _____

Did you receive any injury or bruise from the seat belt (i.e. breast or abdomen)?
YES NO
If YES, then describe: _____

What is the estimated cost damage to the vehicle you were in? $ _____

Which of the following car parts broke during the accident? (please circle)
windshield front seat back
right/left side window other_____
steering wheel other_____

Was the trunk of your body pointed straight forward at the time of the collision?
YES NO; If no, how was it turned?_____

Was you head pointed straight forward? YES NO; If no, what direction was it turned and by how much?_____

What is the year, make and model of the **other** vehicle?
year _____ make _____ model _____

Please give your best description of what happened during this accident:
_____
_____
_____
_____