PATIENT INFORMATION & HISTORY

1 *PATIENT INFORMATION*

Date: _____
Patient:_____
Address:_____
City:_____State:_____Zip:_____
Sex: M F Age: _____ Birth date:_____
Email Address: _____
Single __ Married __ Widowed __ Separated __ Divorced __
Patient SS#: _____
Occupation: _____
Employer: _____
Employer Address: _____
Spouse's Name: _____
Birth date: _____ SS#: _____
Occupation: _____
Spouse's Employer: _____
Whom may we thank for referring you: _____
_____

2 *INSURANCE*

Who is responsible for this account? _____
Relationship to patient: _____
Insurance Company: _____
Subscriber's ID#: _____ Group #: _____
Is patient covered by additional insurance? Yes __ No __
Subscriber's Name: _____
Birth date: _____ SS#: _____
Relationship to patient: _____
Insurance Company: _____
Subscriber's ID#: _____ Group #: _____

ASSIGNMENT & 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.

Responsible Party Signature: _____
Relationship: _____ Date: _____

3 *PHONE NUMBERS*

Home_____ Work_____ Ext.__

IN CASE OF EMERGENCY CONTACT:

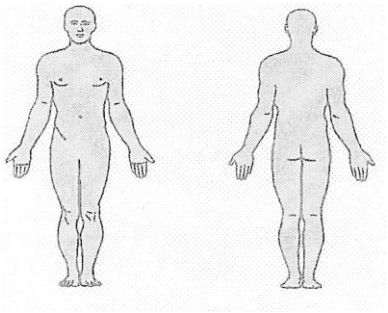
Name: _____ Relationship:_____
Home phone:_____ Work phone:_____

4 *ACCIDENT INFORMATION*

Is condition due to an accident? □ Yes □ No Date:_____
Type of accident □ Auto □ Work □ Home □ Other _____
To whom have you made a report of your accident?
□ Auto insurance □ Employer □ Workers Comp. □ Other
Attorneys name (if applicable): _____

5 *PATIENT CONDITION*

Reason for visit: _____
When did your symptoms first appear? _____ _____
Is this condition getting progressively worse? □ Yes □ No □ Unknown
Mark an X on the picture where you have or had the pain, numbness, tingling, etc.
Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____
Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Stiffness □ Cramps □ Swelling □ Other
How often do you have this pain?
( ) Occasional – 0 to 25% of awake time ( ) Intermittent – 26% to 50% of awake time
( ) Frequent – 51% to 75% of awake time ( ) Constant – 76% to 100% of awake time
Does it interfere with your: □ Work □ Sleep □ Daily routine □ Recreation
Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Lifting □ Bending □ Lying down



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Simi Chiropractic Health Center
2256 Tapo St.
Simi Valley, CA 93063 805-584-1634

6 *HEALTH HISTORY*

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy □ Chiropractic
□ None □ Other _____
Name and address of other doctor(s) who have treated you for your condition: _____
Date of last: Physical exam_____ Spinal X-ray_____ Blood test_____
Spinal exam_____ Chest X-ray_____ MRI_____

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

AIDS?HIV □ Yes □ No	Emphysema □ Yes □ No	Miscarriage □ Yes □ No	Rheumatic Fever □ Yes □ No
Alcoholism □ Yes □ No	Epilepsy □ Yes □ No	Mononucleosis □ Yes □ No	Scarlet Fever □ Yes □ No
Allergy Shot □ Yes □ No	Bone fractures □ Yes □ No	Multiple Sclerosis □ Yes □ No	Stroke □ Yes □ No
Anemia □ Yes □ No	Glaucoma □ Yes □ No	Mumps □ Yes □ No	Thyroid Problems □ Yes □ No
Anorexia □ Yes □ No	Goiter □ Yes □ No	Osteoporosis □ Yes □ No	Tonsillitis □ Yes □ No
Appendicitis □ Yes □ No	Gout □ Yes □ No	Pacemaker □ Yes □ No	Tuberculosis □ Yes □ No
Arthritis □ Yes □ No	Heart disease □ Yes □ No	Parkinson's disease □ Yes □ No	Tumor/Growth □ Yes □ No
Asthma □ Yes □ No	Hepatitis □ Yes □ No	Pinched nerve □ Yes □ No	Typhoid Fever □ Yes □ No
Bleeding disorders □ Yes □ No	Hernia □ Yes □ No	Pneumonia □ Yes □ No	Ulcers □ Yes □ No
Breast lump □ Yes □ No	Herniated disk □ Yes □ No	Polio □ Yes □ No	Vaginal Disorders □ Yes □ No
Bronchitis □ Yes □ No	Herpes □ Yes □ No	Prostate problem □ Yes □ No	Venereal Disease □ Yes □ No
Bulimia □ Yes □ No	High cholesterol □ Yes □ No	Prosthesis □ Yes □ No	Whooping Cough □ Yes □ No
Cancer □ Yes □ No	Kidney disease □ Yes □ No	Psychiatric disorder □ Yes □ No	
Cataracts □ Yes □ No	Liver disease □ Yes □ No	Rheumatoid Arthritis □ Yes □ No	
Chicken Pox □ Yes □ No	Measles □ Yes □ No		
Diabetes □ Yes □ No	Migraines □ Yes □ No		

Please write any conditions not listed above: _____

EXERCISE
□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS
□ Smoking — Packs per day: _____
□ Alcohol — Drinks per day: _____
□ Coffee/Caffinated drinks — Cups per day: _____
□ High stress level — Reason: _____

Date of last menstrual period: _____
Are you pregnant? □ Yes – Due date: _____ □ No

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken bones		
Dislocations		
Surgeries		

7 *MEDICATIONS* *ALLERGIES* *VITAMINS/HERBS/MINERALS*

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