Abundant Life
CHIROPRACTIC

Welcome to our Office!

Please fill out our Health Record as completely and accurately as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you.

"Our mission at ALC is to assist the vital health of our community by allowing families to reach their full potential through chiropractic care."

Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date: / /
SS#: - -	DOB: / /	Sex: ◯ M ◯ F
Marital Status:	# of Children:	Occupation:
Street Address:		Height: ft. in.
City:	State: Zip:	Weight: lbs.
Email:	Cell Phone: - -	Other Phone: - -
Emergency Contact:	Emergency Relation:	Emergency Phone: - -

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professionals? ◯ Yes ◯ No

- If yes, please name them and their specialty:

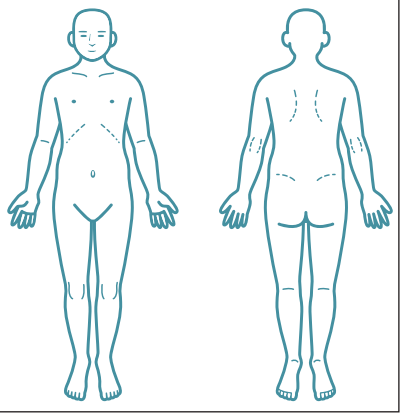
Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.

X= Current condition O= Past condition



Have you received care for this problem before? ◯ Yes ◯ No

- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Is this condition: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals:

1. _____

2. _____

3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ◯ Resolve existing condition(s) ◯ Overall wellness ◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ◯ Yes ◯ No
- If yes, please explain:

Notable childhood injuries? ◯ Yes ◯ No If yes, please explain:

Youth or college sports? ◯ Yes ◯ No If yes, list major injuries:

Any auto accidents? ◯ Yes ◯ No If yes, please explain:

Exercise Frequency? ◯ None ◯ 1-2x per week ◯ 3-5x per week ◯ Daily
What types of exercise?

How do you normally sleep? ◯ Back ◯ Side ◯ Stomach Do you wake up: ◯ Refreshed and ready ◯ Stiff and tired

Do you commute to work? ◯ Yes ◯ No If yes, how many minutes per day?

List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤
Sugar	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

ACKNOWLEDGEMENT & CONSENT

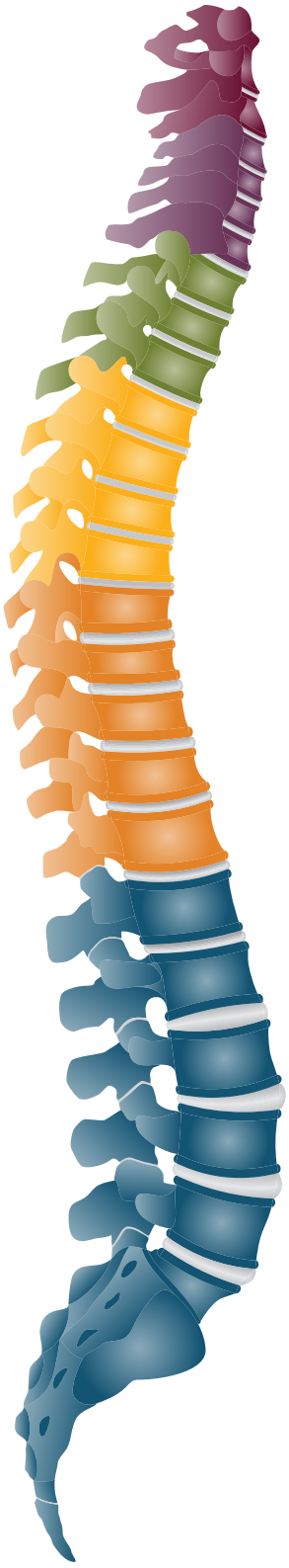
Patient Name: _____ Date: __/__/____

Dr. Jon Torrijos | Abundant Life Chiropractic
8678 19th St. #130, Rancho Cucamonga, CA | 909-483-5433
www.ranchocucamongachiropractor.com

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	Colic & Excessive Crying	☐	☐
		Ear & Sinus Infections	☐	☐
		Allergies & Congestion	☐	☐
		Immune Deficiency	☐	☐
		Headaches & Migraines	☐	☐
		Vertigo & Dizziness	☐	☐
		Sore Throat & Strep	☐	☐
		Swollen Tonsils & Adenoids	☐	☐
		Vision & Hearing Issues	☐	☐
		Low Energy & Fatigue	☐	☐
		Difficulty Sleeping	☐	☐
		Pain, Numbness & Tingling in Arms to Hands	☐	☐
		Epilepsy & Seizures	☐	☐
		Sensory & Spectrum	☐	☐
		ADD / ADHD	☐	☐
		Focus & Memory Issues	☐	☐
		Anxiety & Stress	☐	☐
		Balance & Coordination	☐	☐
		Speech Issues	☐	☐
		TMJ / Jaw Pain	☐	☐
		Stiff Neck & Shoulders	☐	☐
		Depression	☐	☐
		High Blood Pressure	☐	☐
		Poor Metabolism & Weight Control	☐	☐
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	Reflux / GERD	☐	☐
		Chronic Colds & Cough	☐	☐
		Asthma	☐	☐
		Bronchitis & Pneumonia	☐	☐
		Functional Heart Conditions	☐	☐
Mid Thoracic	• Major Digestive Center • Detox & Immunity	Gallbladder Pain / Issues	☐	☐
		Jaundice	☐	☐
		Fever	☐	☐
		Indigestion & Heartburn	☐	☐
		Stomach Pains & Ulcers	☐	☐
		Blood Sugar Problems	☐	☐
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	Behavior Issues	☐	☐
		Hyperactivity	☐	☐
		Chronic Fatigue	☐	☐
		Chronic Stress	☐	☐
		Allergies & Eczema	☐	☐
		Skin Conditions / Rash	☐	☐
		Kidney Problems	☐	☐
		Gas Pain & Bloating	☐	☐
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	Constipation	☐	☐
		Chrohn's, Colitis & IBS	☐	☐
		Diarrhea	☐	☐
		Bed-wetting	☐	☐
		Bladder & Urination Issues	☐	☐
		Cramps & Menstrual Issues	☐	☐
		Cysts & Endometriosis	☐	☐
		Infertility	☐	☐
		Impotency	☐	☐
		Hemorrhoids	☐	☐
		Sciatica & Radiating Pain	☐	☐
		Lumbopelvic / SI Joint Pain	☐	☐
		Hamstring Tightness	☐	☐
		Disc Degeneration	☐	☐
		Leg Weakness & Cramps	☐	☐
		Poor Circulation & Cold Feet	☐	☐
		Knee, Ankle & Foot Pain	☐	☐
		Weak Ankles & Arches	☐	☐
		Lower Back Pain	☐	☐
		Gluten & Casein Intolerance	☐	☐

Patient Name: _____ Date: ___/___/___

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic (**Dr. Jon Torrijos**) and/or his preceptor and/or other licensed doctors of chiropractic who now or in the future care for me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic including those working at the office listed below or any other office. I have had an opportunity to discuss with the doctor and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to care including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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.

Chiropractic care involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of care in this office. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information relayed by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, Abundant Life Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, care provided and any plans for future care. I understand that this information serves as a basis for planning my care; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided. I understand and have been provided with information that provides a more complete description of information uses and disclosures. I understand that I have the right to review this information prior to signing this consent. I understand that Abundant Life Chiropractic reserves the right to change their information, policies and practices, and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out care, payment, or healthcare operations and that Abundant Life Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Abundant Life Chiropractic has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent for Chiropractic Adjustments and Care. 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 form to cover the entire course of care for my present condition and for any future condition(s) for which I seek care.

_____	_____
Patient Name (Printed)	Date Signed
_____	_____
Signature: Patient or Legal Representative (Attorney, Guardian, Parent)	Witness to Signature
_____	_____
Doctor of Chiropractic Signature	Date Signed

FOR DOCTOR'S USE ONLY

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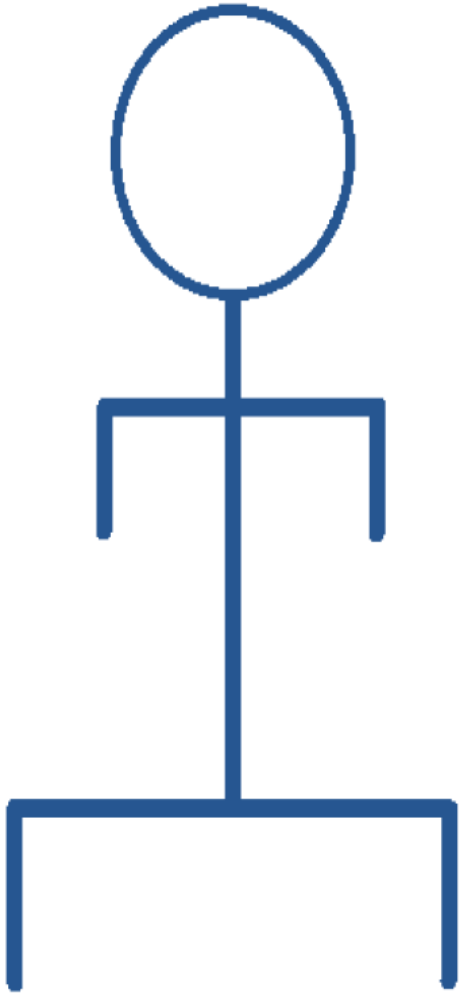

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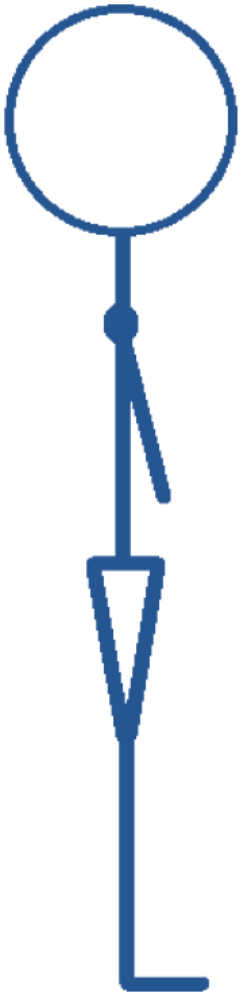

EXAM FINDINGS

HISTORY