PATIENT INFORMATION FORM

First Name:_____ Int: ___ Last Name: _____ Phone:_____
Address:_____ City:_____State:____Zip Code:_____
E-mail:_____
Age:____ Sex:____ Birth Date:__/__/____ Marital Status: S/M/W/D SSN#:___-__-_____
Employer: _____Occupation:_____Phone: (___) ___-____
Work Address:_____City:_____State:____Zip:_____
Person Responsible for this Account:_____
Insurance info: Med. ID#: _____Worker's Comp:_____Auto:_____Policy#_____
Name of Insured:_____Group#:_____Relation to Patient_____
Insurance Co.:_____Insurance Address:_____
City:_____State:_____Zip Code:_____

WHAT IS YOUR MAJOR COMPLAINT?_____
_____
Condition Due To: Auto:__ Work injury:_____Other Accident:_____Illness:_____
Unknown Cause:_____Date Symptoms Appeared:_____
Are Symptoms improving?_____Getting Worse?_____About the Same:_____
Circle Activities Which Aggravate Your Condition:
Standing Walking Sitting Lying Bending Lifting Twisting Coughing Stooping
Have You Had These Symptoms Before: Yes____No____If So, When?_____
Have You Seen Another Doctor For this Condition? Yes____No____M.D./ D.C./ D.O.
Doctor's
Name:_____Phone:_____Address:_____

****

PLEASE READ AND SIGN

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance to come directly to this office with the understanding that all monies will be credited to my account upon receipt of my payment. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I authorize the release of X-rays and information regarding my health status. I hereby authorize the Dr. to treat my condition as he deems appropriate. It is understood and agreed the amount paid the Dr. for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Patient's Signature:_____Date:_____
Consent to Treat a Minor:_____Date:_____
Guardian or Spouse's
Signature of Authorizing Care_____Date: _____

POWER INN CHIROPRACTIC
ROBERT L HULBERT, DC, QME

CONSENT TO TREAT

Pursuant to the California Code of Regulations, Title 16, Div.4, Article 2, Section 319.1, a Consent to Treat must be signed prior to receiving Chiropractic care.

I consent to the performance of chiropractic adjustments and procedures which may be performed by any of the chiropractors or their assistants at Power Inn Chiropractic, Inc. This consent will remain valid for the duration of treatment and includes any emergency home visits.

The procedures include various forms of manual therapy, spinal decompression, Class IV healing laser and diagnostic X-rays. All though rare, possible risks include, however are not limited to: fractures, disc injuries, strokes, dislocations, and sprains.

I have read and agree with the above Consent to Treat. I have had an opportunity to ask questions about its content, and about the suggested treatment.

I understand that all information provided by me during the course of treatment will remain confidential.

Patient Signature _____ Date _____

Legal Guardian (if required) _____ Date _____

Witness Signature _____ Date_____

8280 Folsom Boulevard, Suite A, Sacramento, CA 95826
Office: 916.387.1007 Fax: 916.387.9843
drhulbert.com/sacramentochiropractor.com

SYMPTOM SURVEY

GENERAL SYMPTOMS. (Circle as many as apply)

A) Nervousness F) Tension K) Anxiety
B) Irritability G) PMS L) Bruised 1)Yes 2) No
C) Fatique H) Jaw Pain How Many -
D) Depression I) Dizzyness Where-
E) Loss of sleep J) Memory loss

HEAD. (Circle as many as apply)

A) Headache- 1) Minimal 2) Slight 3) Moderate 4) Severe
How often: (1 2 3 4 5 6) (per day, week, month)
Are they: 1) Sharp 2) Dull 3) Throbbing 4) Tingles
Are they: 1) Constant 2) Intermittent:_____% of the time
Located: 1) Back of head 2) Forehead 3) Temples
4) Right side 5) Left side 6) Behind eyes
B) Light headed E) Blurred vision H) Loss of balance
C) Memory Loss F) Double vision I) Hearing Loss
D) Fainting G) Sensitive to light J) Ringing in ears

NECK. (Circle as many as apply)

A) Pain- 1) Left side 2) Right side 3) Both sides
Pain Level - 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:_____% of the time
Pain increased by: 1) Forward movement
2) Backward movement 3) Rotate head left 4) Rotate head right
5) Bend neck left 6) Bend neck right
B) Stiffness C) Muscle spasm D) Grinding and grating sounds

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
Tension 1) Left 2) Right 3) Both
Pain Level- 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:_____% of the time

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
Pain Level- 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:_____% of the time

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 and needles (hand) 1) Left 2) Right 3) Both
D) Numbness (hand) 1) Left 2) Right 3) Both
Pain Level- 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:_____% of the time

MIDBACK. (Circle as many as apply)

A) Pain- 1) Left side 2) Right side 3) Both sides
Pain Level - 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:_____% of the time
Pain Type- 1) Sharp/Stabbing 2) Dull ache 3) Throbbing
B) Muscle spasm- 1) Left side 2) Right side 3) Both sides

CHEST. (Circle as many as apply)

A) Chest pain - 1) Left side 2) Right side 3) Both sides
Pain Level - 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:_____% of the time
B) Pain around ribs- 1) Left side 2) Right side 3) Both sides
1) Sharp/Stabbing 2) Dull ache 3) Throbbing
C) Shortness of breath
D) Irregular heartbeat

ABDOMINAL SYMPTOMS. (Circle as many as apply)

A) Pain Level - 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:_____% of the time

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

LOW BACK. (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) Sacro-lilac pain 1) Left 2) Right 3) Both
D) Muscle spasm- 1) Left 2) Right 3) Both
Pain Level - 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:____% of the time

HIPS AND LEGS. (Circle as many as apply)

A) Pain in buttocks- 1) Left 2) Right 3) Both sides
Pain Level- 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:_____% of the time

B) Pain in hip joint- 1) Left 2) Right 3) Both sides
Pain Level- 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequecy: 1) Constant 2) Intermittent:_____% of the time

C) Pain down leg- 1) Left 2) Right 3) Both sides
Location 1) Front 2) Back 3) Side
Pain radiates to: 1) Knee 2) Calf 3) Foot
Frequecy: 1) Constant 2) Intermittent:_____% of the time
D) Numbness down leg- 1) Left 2) Right 3) Both
E) Pins & needles (legs) 1) Left 2) Right 3) Both
F) knee pain- 1) Left 2) Right 3) Both
G) Leg cramps 1) Left 2) Right 3) Both

FOOT/ANKLE. (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 foot 1) Left 2) Right 3) Both
E) Swollen feet- 1) Left 2) Right 3) Both
F) Cramps 1) Left 2) Right 3) Both
Pain Level- 1) Minimal 2) Slight 3) Moderate 4) Severe
Frequency: 1) Constant 2) Intermittent:_____% of the time

Vehicle Accident Report

Name_____

1) Date of accident____/____/____ Time of accident____:____(am/pm)

3) Were you a) Driver b) Passenger (front) c) Van d) Motorcycle e) Motorhome f) Bicycle

4) Were you wearing seatbelts? (Y/N)

5) Type of Vehicle: a) Auto b) Truck c) Van d) Motorcycle e) Motorhome f) Bicycle

6) How accident occurred: a) Struck by another vehicle b) Struck another vehicle c) Struck a stationary object d) other

7) Where was your vehicle hit? a) Front b) Rear c) Rt. Side d) Lft. Side e) Rt. Front f)Lft. Front g) Rt. Rear h) Lft. Rear

8) Where was the other vehicle hit? a) Front b) Rear c) Rt. Side d) Lft. Side e) Rt. Front f) Lft. Front g) Rt. Rear h) Lft. Rear

9) Your approximate speed ____MPH 10) other vehicle approximate speed ____MPH

11) What occurred at the moment of impact? (Circle as many that apply)

a) Tensed body for impact b) Neck whipped froward & back c) Spine torqued & twisted d) Thrown over seat

e) Thrown from vehicle f) Pinned in vehicle g) Thrown from side to side h) Cut & Bruised

12) Did you strike your: (circle as many that apply)

A) Head Agnst: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown

B) Shoulder Lft/Rt Agnst: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown

C) Arm Lft/Rt Agnst: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown

D) Elbow Lft/Rt Agnst: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown

E) Wrist Lft/Rt Agnst: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown

F) Hip Lft/Rt Agnst: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown

G) Knee Lft/Rt Agnst: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown

H) Ankle Lft/Rt Agnst: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown

13) Were you rendered unconscious? (Y/N) 14) Did you receive medical attention at the scene of the accident? (Y/N)

15) Where did you go immediately following the accident? a) Hospital b) Home c) Personal Dr. d) To this office e) Cont. Activities

16) Were you: (circle as many as apply) a) Shaken b) Disoriented

Did you have any physical complaints before the accident? (Y/N) If "YES" please describe:

_____

_____

_____

In your own words, please describe the accident:

_____

_____

_____

How did you feel immediately after the accident?

_____

_____

_____

Important: This form may be use in the determination of insurance benefits &/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

PATIENT NAME:_____

Check each of the activities that you have **difficulty** performing and or can perform only with pain. (There is no particular priority in the order presented.)

HOUSEWORK

_____Doing laundry
_____Vacuuming
_____Washing dishes
_____Ironing
_____Making beds
_____Carring groceries
_____Caring for pets
_____Cooking
_____Other

YARDWORK

_____Mowing the lawn
_____Shoveling snow
_____Raking leaves
_____Gardening

GENERAL

_____Walking
_____Standing
_____Running
_____Lifting children
_____Bending
_____Climbing stairs
_____Reading
_____Lying in bed
_____Chewing
_____Sports:

List_____

PERSONAL GROOMING

_____Combing hair
_____In/out bathtub
_____Brushing teeth
_____Shaving
_____Other

TRAVEL

_____Driving
_____Riding (passenger)

Minutes per day
Type of vehicle
Auto_____
Train_____
Bus_____
Truck_____
Airplane_____

_____Getting in/out of auto
_____Playing piano
_____Using typewriter/computer
_____Kneeling
_____Sexual intercourse
_____Exercising
_____Sleeping
_____Using the telephone
_____Sitting in recliner
_____Swimming

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:

_____

_____

Signed_____Date_____