

Patient Information

Date _____
Patient Name (Last Name) _____
(First Name) _____
(Middle Initial) _____
Email _____
Address _____
Apt./Ste. _____
City _____
State Zip _____
Sex M F Age _____
Birth Date _____
 Married Single Divorced
 Domestic Partner

Phone Numbers

Cell Phone _____
Home Phone _____
Best time and place to reach you

In Case of Emergency, Contact

Name _____
Relationship _____
Home Phone _____
Cell Phone _____

Health Insurance Provider:

Patient Employer/School _____

Occupation _____

Who may we thank for referring you?



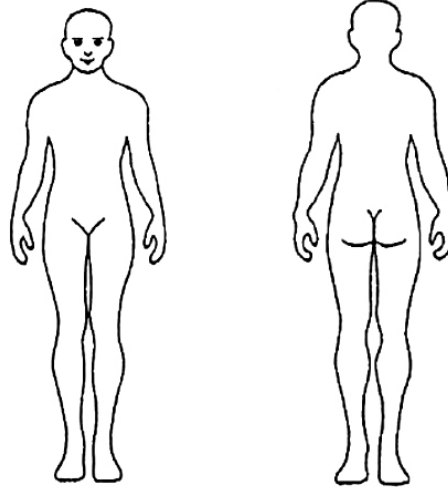
2850 Artesia Blvd. Ste.201
Redondo Beach, CA
90278
310.978.7807

Patient Condition

Chief Complaint _____
When did your symptoms appear?

Is this condition getting progressively worse?
 Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull
 Throbbing Numbness
 Aching Shooting Burning
 Tingling Cramps Stiffness
 Swelling Other _____

How often do you have this pain?

Is it constant or does it come and go?

Does it interfere with your:
 Work Sleep Daily Routine
 Recreation NA

Activities or movements that are painful to perform:

Sitting Standing Walking Bending
 Lying Down NA

Health Information

What treatment have you already received for your condition? Medications Surgery

Physical Therapy Chiropractic Services 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 _____ Urine Test _____
 Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

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

AIDS/HIV	Yes No	Chicken Pox	Yes No	Kidney Disease	Yes No	Rheumatoid Arthritis	Yes No
Alcoholism	Yes No	Corticosteroid	Yes No	Liver Disease	Yes No	Rheumatic Fever	Yes No
Allergy Shots	Yes No	Diabetes	Yes No	Measles	Yes No	Scarlet Fever	Yes No
Anemia	Yes No	Emphysema	Yes No	Migraines	Yes No	Stroke	Yes No
Anorexia	Yes No	Epilepsy	Yes No	Miscarriage	Yes No	Suicide Attempt	Yes No
Appendicitis	Yes No	Fatigue	Yes No	Mononucleosis	Yes No	Thyroid Problem	Yes No
Arthritis	Yes No	Fractures	Yes No	MS	Yes No	Tonsillitis	Yes No
Asthma	Yes No	Glaucoma	Yes No	Mumps	Yes No	Tuberculosis	Yes No
Birth Control Pills	Yes No	Goiter	Yes No	Osteoporosis	Yes No	Tumors, Growths	Yes No
Bleeding Disorder	Yes No	Gonorrhea	Yes No	Pacemaker	Yes No	Typhoid Fever	Yes No
Breast Lumps	Yes No	Gout	Yes No	Parkinson's	Yes No	Ulcers	Yes No
Bronchitis	Yes No	Headaches	Yes No	Pinched Nerve	Yes No	Vaginal Infections	Yes No
Bulimia	Yes No	Heart Disease	Yes No	Pneumonia	Yes No	Venereal Disease	Yes No
Cancer	Yes No	Hepatitis	Yes No	Polio	Yes No	Whooping Cough	Yes No
High Cholesterol	Yes No	Hernia	Yes No	Prostate Problems	Yes No	Other: _____	
Chemical. Dep.	Yes No	Herniated Disc	Yes No	Psychiatric Care	Yes No		
Chest Discomfort	Yes No	Herpes	Yes No	Rapid Heartbeats	Yes No		

Are you pregnant? Yes No Due Date _____

Please list all Injuries/Surgeries you have had:

Description	Date
Falls _____	_____
Head Injuries _____	_____
Broken Bones _____	_____
Dislocations _____	_____
Surgeries _____	_____

Lifestyle

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Medications

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

Allergies

- 1) _____
- 2) _____
- 3) _____
- 4) _____

How often do they occur?

Vitamins/Supplements

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Daily Weekly Occasionally

If more space is needed, please use the back of this page.

Is there any additional information you feel as if you need to express that has not been covered in this patient intake form? _____

The statements made as to the questions asked on this form are accurate to the best of my knowledge, and I agree to allow this office to examine me for further evaluation. I understand that any and all information on this form and in this file will remain confidential to myself, the doctor, and any other authorized personnel.

X _____
Patient/Legal Guardian Signature



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