

WEST COAST



CHIROPRACTIC

Date: _____ Referred by: _____

Patient Name: _____ Social Security #: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Birth Date: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____

Marital Status: Married Single Divorced Widowed Number of Children: _____

Spouse's Name: _____

Have you previously had Chiropractic Care? _____ If yes, when? _____ Did it help? _____

List your problems in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

What activities make your condition worse? _____

Has this problem been getting better, worse, or staying the same? _____

How many hours a day do you sit at a computer? _____ How many hours a day are you on the phone? _____

Have you been involved in an auto accident in the last 12 months? _____ Do you have health insurance? _____

Name of insurance company: _____

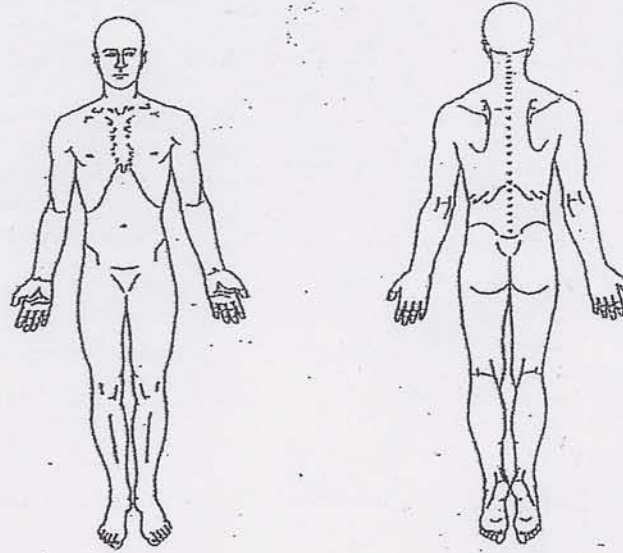
Medications you take now: Aspirin Pain Killers Tranquilizers Insulin Birth Control Pills Other (please list) _____

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- RELIEF CARE: Symptomatic relief of pain or discomfort
- CORRECTIVE CARE: Correcting the cause of a problem as well as the symptoms
- COMPREHENSIVE CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the doctor to select the type of care appropriate for my condition

Patient signature: _____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity, which brings on or aggravates the pain. For example, describe as dull, sharp, constant, off & on, when standing, when sitting, etc.



Check appropriate squares (x) past or (✓) present condition:

- Headaches
- Nervousness
- Insomnia
- Head colds
- High blood pressure
- Migraines
- Nervous breakdown
- Chronic tiredness
- Dizziness
- Sinus troubles
- Eye problems
- Excessive sweating
- Ear ache
- Ulcers
- Stomach troubles
- Indigestion
- Heartburn
- Gastritis
- Lowered resistance
- Diabetes

- Mental, emotional conditions
- Convulsions
- Acne
- Eczema
- Hay Fever
- Adenoids
- Hearing loss
- Ringing ear
- Laryngitis
- Hoarseness
- Sore throat
- Tonsillitis
- Croup
- Poor circulation
- Swollen ankles
- Cold feet
- Weakness in legs
- Leg cramps
- Hemorrhoids (piles)

- Bursitis
- Thyroid condition
- Asthma
- Cough
- Difficult breathing
- Shortness of breath
- Heart condition
- Bronchitis
- Pleurisy
- Pneumonia
- Congestion
- Influenza
- Gall bladder condition
- Jaundice
- Shingles
- Liver condition
- Fever
- Low blood pressure
- Arthritis

- Kidney troubles
- Constipation
- Colitis
- Dysentery
- Diarrhea
- Ruptures
- Hernias
- Cramps
- Varicose veins
- Bladder troubles
- Menstrual problems
- Miscarriages
- Bed wetting
- Impotency
- Change of life symptoms
- Knee pain
- Sciatica
- Difficult urination
- Painful urination
- Frequent urination

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.

Our office uses sign in sheets, travel cards and provides care in an "open door" adjusting environment. Adjustments are done in an open adjusting area. As a result patients are in sight of each other and some ongoing routine details of care may be in earshot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity. In addition your signature below authorizes us to contact you at all the phone numbers/addresses you list on this intake form. If you do not wish to be contacted at any listed numbers/addresses, please let us know.

Patient's Signature _____

Date _____

Privacy Policy Received

Patient's Signature _____

Date _____