Community Chiropractic

About the Patient

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Email Address: _____

Birthdate: _____ Age: _____

Gender: M ☐ F ☐ Number of Children: _____

Employer: _____

Work Address: _____

City, State, Zip: _____

Work Phone: _____

Type of Work: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Payment Method: ☐ Cash ☐ Check ☐ Credit Card

Phone: (408)778-3020
16375 Monterey Road, Unit B • Morgan Hill, CA 95037
Fax 408-778-0803 • www.conraganchiro.com

Health History

Past Injuries? _____

_____

_____

Past allergic reactions? _____

_____

_____

Past Surgeries? _____

_____

_____

Hospitalizations? _____

_____

_____

About the Spouse/Parent

Name: _____

Employer: _____

Work Phone: _____

Type of Work: _____

Reason for My Visit

Reason for visit: _____

_____

Overall Frequency of Complaint: (circle one please)
Constant - 100% Frequent - 75% Intermittent - 50% Occasional - 25%

Overall Intensity of Complaint: (circle one please)
- Minimal *(An annoyance, no effect on activity)*
- Moderate *(Tolerable,marked impairment of activity)*
- Slight *(Tolerable, some impairment to activity)*
- Severe *(Intolerable, cannot perform any activities)*

Is your problem affecting any other area of your body?
If yes, explain: _____

_____

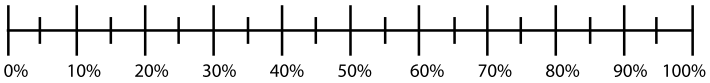
Does it interfere with your normal daily activities (family, recreation, sports)? How?

_____

_____

Does your symptoms increase while performing your normal work duties?
(circle one please) Y N

If yes, please place an "X" at the amount below that you feel your symptoms increase at work:



What aggravates the problem? _____

_____

What relieves the problem? _____

_____

If this went without being taken care of, how do you think it would affect you?

_____

Any questions or concerns? _____

_____

Patient's Signature: _____ ***Date:*** _____

Experience with Chiropractic

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? ☐ ***Yes*** ☐ ***No***

Reason for those visits? _____

Doctor's Name: _____

Approximate date of last visit? _____

Has any ADULT in your family seen a Chiropractor? ☐ ***Yes*** ☐ ***No***

Has any CHILD in your family seen a Chiropractor? ☐ ***Yes*** ☐ ***No***

Awareness of Chiropractic Principles

Were you aware that

- ...Doctors of Chiropractic work with the nervous system? Yes No
- ...the nervous system controls all bodily functions and systems? Yes No
- ...Chiropractic is the largest natural healing profession in the world? Yes No
- ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

Goals for My Care

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 treatment program. 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 and relieving the cause of the 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's Signature | Date

Medications I Now Take

☐ ***Nerve Pills***

☐ ***Pain Killers (including aspirin)***

☐ ***Muscle Relaxers***

☐ ***Blood Pressure Medicine***

☐ ***Insulin***

☐ ***Stimulants***

☐ ***Blood Thinners***

☐ ***Tranquiliziers***

☐ ***Other:*** _____

☐ ***Other:*** _____

Health Habits

Do you smoke? ☐ ***No*** ☐ ***Yes*** _____ ***packs per day***

Do you drink alcohol? ☐ ***No*** ☐ ***Yes*** _____ ***drinks per day***

Do you drink coffee? ☐ ***No*** ☐ ***Yes*** _____ ***cups per day***

Do you exercise regularly? ☐ ***No*** ☐ ***Yes*** ☐ ***Moderate*** ☐ ***Daily***

Do you wear... ☐ ***Heel Lifts*** ☐ ***Sole Lifts*** ☐ ***Inner Soles*** ☐ ***Arch Supports*** ☐ ***No***

Health Conditions

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Severe or Frequent Headaches
☐ Sinus Problems
☐ Dizziness
☐ Loss of Sleep
☐ Pain Between the Shoulders
☐ Frequent Neck Pain
☐ Numbness or Pain in Arms/Legs/Hands
☐ Lower Back Problems
☐ Digestive Problems
☐ Ulcers/Colitis
☐ Heart Attack/Stroke

☐ Congenital Heart Defect
☐ Heart Surgery/Pacemaker
☐ Heart Murmur
☐ High/Low Blood Pressure
☐ Difficulty Breathing
☐ Asthma
☐ Arthritis
☐ Alcohol/Drug Abuse
☐ Veneral Disease
☐ Diabetes
☐ Tuberculosis

☐ Shingles
☐ Kidney Problems
☐ Cancer
☐ Chemotherapy
☐ Anemia
☐ Rheumatic Fever
☐ Psychiatric Problems
☐ Thyroid Problems

For Women

Are you pregnant?	Yes ☐	No ☐
Are you nursing?	Yes ☐	No ☐
Are you taking birth control?	Yes ☐	No ☐
Experience painful periods?	Yes ☐	No ☐
Do you have irregular cycles?	Yes ☐	No ☐
Do you have breast implants?	Yes ☐	No ☐

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature | Date

Guardian/Spouse's Signature Authorizing Care | Date

Who should receive bills for payment on your account?

☐ Patient ☐ Spouse ☐ Parent ☐ Worker's Comp ☐ Auto Insurance
☐ Medicare ☐ Medicaid ☐ Personal Health Insurance

Ownership of X-ray Films.
It is understood and agreed that the payments to the Doctor for the X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient at this office.

Emergency Contact

Name:

Relationship:

Work Phone:

Home Phone:

Cell Phone:

About My Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance comany and that any amount to be paid directly to the Doctor's Office will be credited to my account on receipt.

Insurance Co. Name: Group Number (Plan, Local, Policy #):

Address: Phone:

About the Insured Person

Name: Insured's Social Security #:

Relation: Date of Birth:

Employer: