Silicon Valley Chiropractic Center

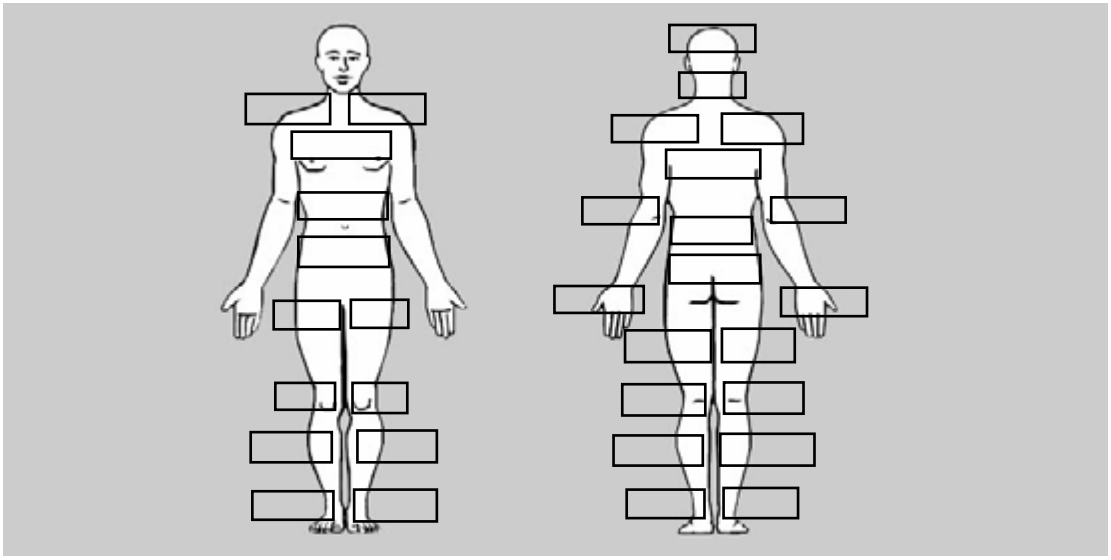
Patient Name: ..... Today's Date: .....
Address: ..... City: ..... State: ..... Zip: .....
Home Phone: ..... Cell Phone: .....
Birthdate: ..... Age: ..... Male: ☐ Female: ☐
Social Security No: ..... (Required for Verifying Insurance)
Marital Status: Single ☐ Married ☐
Email Address: ..... Who referred you to our office?: .....
Primary Care Physician: ..... Phone: .....

EMPLOYER INFORMATION

Employer: ..... Occupation: .....
Work Address: ..... City,State,Zip: .....
Work Phone: .....

BODY DIAGRAM

Please use the KEY below to mark the exact location of your concerns/symptoms on the body diagram.
A = *Aching* **D** = *Dull* **P** = *Pain* **N** = *Numbness* **S** = *Sharp* **SH** = *Shooting* **T** = *Tingling* **W** = *Weakness*



Is your current injury/ illness work related? Yes ☐ No ☐

f YES, have you reported it to your employer? Yes ☐ No ☐

Is your current injury related to an auto accident? Yes ☐ No ☐

Is your current injury/ illness work related? Yes ☐ No ☐

List Your Chief Concerns (Pain , symptoms, Etc.) In Order of Severity

1. ..... For How Long? .....
2. ..... For How Long? .....
3. ..... For How Long? .....

Other Doctors seen for this problem: Chiropractor ☐ Medical Doctor ☐ Other ☐
What caused these conditions? (Fall, Accident, Lifting, Work Related, etc.): .....
Date of Injury (if applicable): .....
What activities make your condition worse?: .....

INSURANCE

Do you have Health Insurance? Yes ☐ No ☐ Is the insurance coverage through your spouse? Yes ☐ No ☐
Name of Insurance Company: ..... Is it: PPO ☐ EPO ☐ POS HMO ☐
If spouse is the primary carrier, please complete following information:
Spouse Full Name: ..... Spouse Birthdate: .....

HEAD, NECK, BACK and EXTREMITIES – Check those applicable to you.

HEAD
- ☐ Headache
- ☐ Migraine
- ☐ Sinus Headache
- ☐ Dizziness
- ☐ Lightheaded ☐ Muscle Spasm
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Jaw Pain

NECK
- ☐ Pain
- ☐ Stiffness
- ☐ Grinding
- ☐ Muscle Spasm
- ☐ "Pinched Nerve"
- ☐ Restricted Motion
- ☐ Weakness

LOWER BACK
- ☐ Pain
- ☐ Stiff
- ☐ Tension
- ☐ Weakness
- ☐ "Pinched Nerve"
- ☐ Feels "out of place"

Symptoms worse with:
- ☐ Sitting
- ☐ Standing
- ☐ Bending
- ☐ Stooping
- ☐ Twisting
- ☐ Lifting
- ☐ Coughing

SHOULDERS
- ☐ Pain across shoulders
- ☐ Pain in shoulder Joint
- ☐ Pain with movement
- ☐ Difficulty raising arm
- ☐ Restricted Motion
- ☐ Tension

MID & UPPER BACK
- ☐ Pain
- ☐ Stiff
- ☐ Tension
- ☐ Muscle Spasm
- ☐ "Pinched Nerve"

ARMS and HANDS

☐ Pain		
☐ Weakness	☐ Left	☐ Right
☐ Numb /Tingly	☐ Left	☐ Right
☐ Pins /Needles	☐ Left	☐ Right
☐ Cold Hands	☐ Left	☐ Right

HIPS, LEGS & FEET

☐ Buttock Pain	☐ Left	☐ Right
☐ Hip Pain	☐ Left	☐ Right
☐ Knee Pain	☐ Left	☐ Right
☐ Ankle Pain	☐ Left	☐ Right
☐ Numb/Tingly Thigh	☐ Left	☐ Right
☐ Numb/Tingly Leg	☐ Left	☐ Right
☐ Numb/Tingly Feet	☐ Left	☐ Right
☐ Weakness	☐ Left	☐ Right
☐ Cold Feet	☐ Left	☐ Right

HEALTH HISTORY

- ☐ AIDS /HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Aneurysm
- ☐ Atherosclerosis
- ☐ Arthritis
- ☐ Ankylosing Spond.
- ☐ Degenerative Arth
- ☐ Rheumatoid Arth.
- ☐ Asthma
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Childhood onset
- ☐ Adult onset
- ☐ Drug Dependency
- ☐ Epilepsy
- ☐ Fracture
- ☐ Glaucoma
- ☐ Heart Problems
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate
- ☐ Prosthesis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors

General Symptoms
- ☐ Coughing up Blood
- ☐ Depressed
- ☐ Fainting Spells
- ☐ Fatigue
- ☐ Loss of Balance
- ☐ Loss of Coordination
- ☐ Loss of Sleep
- ☐ Shortness of Breath
- ☐ Weakness, general

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Rapid Heart Beat

Eye, Ear, Nose & Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Difficult Swallowing
- ☐ Double Vision
- ☐ Nose Bleeds
- ☐ Persistent Cough
- ☐ Visual Disturbances

Genitourinary
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Urinary Incontinence

Social History
- ☐ Smoke
- ☐ Other Tobacco
- ☐ Alcoholism
- ☐ Balanced Diet ☐ **Yes** ☐ **No**
- ☐ Sufficient Rest ☐ **Yes** ☐ **No**

Gastrointestinal
- ☐ Bloating
- ☐ Bloody Stool
- ☐ Excessive Thirst
- ☐ Feeling of Fullness
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Skin & Nails
- ☐ Blue/Purple Skin
- ☐ Blue/Purple Nail beds
- ☐ Mole Changes
- ☐ Non-healing Sores
- ☐ Swollen Ankles

Have you had any surgeries or procedures? ☐ Yes ☐ No

If Yes, what and when?

_____

_____

_____

WOMEN ONLY

☐ Bleeding between Periods ☐ Breast Lump ☐ I am Pregnant
☐ Taking Birth Control Pills ☐ Abnormal Pap Smear ☐ Menstrual Pain
Date last Period_____ Date last GYN exam_____

NOTICE OF PRIVACY PRACTICES

I have read the Privacy Notice and Understand my rights contained in the notice. By way of my signature, I provide Silicon Valley Chiropractic Center with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

_ _____ Initial

ASSIGNMENT OF BENEFITS

This is a direct assignment of rights and benefits under my insurance policy. I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_ _____ Initial

NOTICE

PATIENTS MAY REQUIRE X-RAYS TO DETERMINE WHAT TYPE OF CARE AND LENGTH OF CARE THE PATIENT WILL REQUIRE.

1. **All first visits charges are payable when services are rendered.**
2. The fee for x-rays is for analysis only. California State Law requires we maintain your x-rays. X-Ray's may be send to another medical facility with authorization only.

I (Printed Name) _____ (Initials) _____

have clearly read, understand and agree to all the terms and conditions noted above (Date)_____

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