Le Chiropractic

2101 Natomas Crossing Drive #300, Sacramento, CA 95834 Tel: 916-928-4545 Fax: 916-928-4544

Name________________________SS#_______________ Drive License #______________

Sex:___Age:____ Birthdate:____________Marital Status: Married Single Divorced Widowed # Children________

Home Address___________________________City_______________State_______Zip_________

Home Phone #_______________Cell #_______________Email____________________

Work Company & Address________________________________Work#______________

Occupation ____________________ Job Title __________________ How Long?____________

Spouse's Name______________ Occupation____________________ Phone #______________

Whom may we thank for referring you? ____

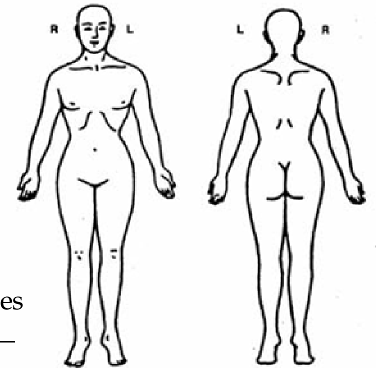
Have you had previous chiropractic care? ☐Yes ☐No If Yes, Name of doctor______________________

HEALTH INFORMATION

Reason for today's visit: ☐Emergency ☐New Injury ☐Old Injury ☐Chronic Pain ☐Wellness visit

Are you in pain: ☐Yes ☐No **Using the adjacent body charts, please circle all affected areas.**

Please rate your pain scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense



Did your injury occur during: ☐Auto Accident ☐Home Activities ☐Work ☐Sports/Play

When did your condition / accident occur? Date ______________ Time __________

Please explain what happened: ____

Have you have similar condition in the past? ☐Yes ☐No When? ______________

Is this condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and goes

Does your condition interfering with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Are you taking any of the following medications? ☐ Nerve Pills ☐Pain Killers ☐Muscle relaxes ☐Blood Thinner ☐Tranquilizers ☐Insulin Other(s) ______________________

Do you have or have you had any of the following diseases, medical conditions or procedures? Please circle below:

Hear Attacks / Stroke	Heart / Surgery / Pacemaker	Heart Murmur	Congenital Heart Defect	Mitral Valve Prolapse
Artificial Valves	Alcohol / Drug Abuse	Venereal Disease	Hepatitis	Anemia / Diabetes
Shingles	Cancer	Frequent Neck Pain	Glaucoma	Kidney Problems
High / Low Blood Pressure	Psychiatric Problems	Rheumatic Fever	Severe / Frequent Headaches	Tuberculosis
Ulcers / Colitis	Fainting / Seizures / Epilepsy	Sinus Problems	Emphysema / Asthma	Arthritis
Difficulty Breathing	Chemotherapy	Lower Back Problems	Artificial Bones / Joints	HIV or AIDS Infections

INSURANCE INFORMATION

☐Uninsured (Cash) ☐Auto Insurance ☐Work Comp ☐Private Insurance

Insurance Co.______________________________Name of Insured________________

Billing Address___________________________ City_______________State______Zip_________

Claims Representative________________________Phone#___________________Ext. #______

I.D. or Policy #:____________________Claim # ______________________________

☐Medi-Cal ☐Medicare Medi-Cal #_____________________ Date of Issued______________

Medicare #_____________________ Effective Date______________

PAYMENT POLICY

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorized the doctor to release my information including diagnosis and the records of any treatment or examination rendered to me or any child during the period of chiropractic care to third party payers and/or health practitioners. I understand that this office will prepare all necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I understand that my chiropractic insurance may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

Signature____Date________________

☐Adult patient ☐Parent or Guardian ☐Spouse

LE CHIROPRACTIC
Patient History

Patient Name: ______________________ Date_____________

OFFICE USE ONLY:			
HT: __________	WT: __________	BP: _____________	PULSE: ________

Major Complaint: ____

Besides your major complaint, what other health problem(s) do you have that you would like to get rid of? (Include those that may not be within the chiropractic scope of practice)

____

____

O: When and how did this pain/problem start? Was there an accident, injury, or condition that may or may not have been related to this pain/problem?

____

____

P+: What triggers or makes the pain/problem worst? _____________________________

____

P-: What lessens or makes the pain/problem better? _____________________________

____

Q: Describe how the pain/problem feels like? (ie. sharp, sore, achy, etc…)

____

R: Does the pain travel to any other part of your body? ___________________________

____

S: Where is the pain/problem located? ____

____

T: Which time(s) of the day is the pain/problem at its worst? _____________________

____

F: How often do experience this pain/problem? _________________________________

____

I: On a scale of 0 to 10, 0=no pain and 10 being the worst pain you've ever felt, how you would rate the pain:

When it first started: _____ At it's worst: _____ At it's least: _____ Currently: _____

D: When you have the pain/problem, how long does it last for? Does it go away by itself your do you have to take or do something to make it go away? _____________________

____

How is this pain/problem affecting the quality/functions of your daily life? ___________

____