Comprehensive Health and Chiropractic Centre

Family Practice

555 South Rancho Santa Fe Road, Ste. 200
San Marcos, CA 92069
(760) 736-0286 · (760) 736-3113

PERSONAL DATA

Date:_____ Chart Number:_____ Date of Accident: _____

Home phone:_____ Cell phone: _____

Last Name:_____ First Name:_____ M.I.___

Address: _____

City: _____ State:_____ Zip:_____ Work Phone: _____

Birthdate:_____ Age:_____ Sex: M F Height:_____ Weight: _____

Please check one: ❑Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

SSN:_____/_____/_____ Your Driver's Lic.#:_____

Are you/have you been disabled from work?_____

E-mail address: _____

We call you before your appointment to remind you of the appointment. Would you like to be reminded by:

(please check your choice) ❑Telephone ❑E-mail ❑ Text ❑None

If telephone number is selected, which number? 1) Home 2) Cell 3) Work (please circle your choice)

We send text messages (i.e., Happy Birthday) Would you like to receive these messages? ❑ Yes ❑No

Would you like to receive our newsletter by e-mail? ❑ Yes ❑No

BUSINESS DATA

Business phone:_____

Business/Employer:_____

Type of work:_____

Address:_____

City: _____ State:_____ Zip:_____

FAMILY DATA

Spouse's name:_____

Social Security #_____

Business phone:_____

Business/Employer:_____

Type of work:_____

CHILDRENS NAMES

Name_____ Age:_____

Name_____ Age:_____

Name_____ Age:_____

Name_____ Age:_____

EMERGENCY CONTACT

Name and address of nearest relative not living with you:

Name:_____ Relationship: _____

Phone# (Cell) _____ (Home) _____ (Work) _____

REFERRAL

Referred to this office by:_____

Comprehensive Health and Chiropractic Centre

INSURANCE

RESPONSIBLE PARTY

Name of person responsible for this account? _____
Relationship to patient _____
Address _____ City _____ State _____ Zip _____
Name of Employer _____ Work phone# _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____
Birth Date _____ SS# _____ Date employed _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone# ( )_____-_____
Insurance Address _____ City _____ State ___ Zip _____
Group# _____ ID# _____
How much is your deductible? _____ How much have you met? _____
Maximum annual benefit? _____

Do you have additional Insurance? NO_____ YES_____

Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone# ( )_____-_____
Insurance Address _____ City _____ State ___ Zip _____
Group# _____ Employer# _____
How much is your deductible? _____ How much have you met? _____
Maximum annual benefit? _____

PATIENT AGREEMENT

As a courtesy to our patients, Comprehensive Health and Chiropractic Centre is set up to utilize direct payment from insurance companies. However, it is important to understand that your health and accident insurance policy is an arrangement between you and your insurance company. You are personally responsible for all service charges incurred in our office. Until your insurance coverage has been verified, we expect payment in full when the services are rendered.

We ask that you keep our deductible charges current. After your deductible has been met, we request that you continue to keep your portion of your claim up to date. You are required to sign an "authorization and assignment of benefits" from and any other documents required by your insurance company on your first office visit. You are responsible for providing this office with insurance information and claim forms. You will be considered a cash-paying patient until this information is received. Our office does not guarantee that your insurance will pay. Regardless of what type of insurance you have, you are ultimately responsible for your account. Most insurance companies do not cover the cost of vitamin supplements and orthopedic supplies. Therefore, these costs are the responsibility of the patient. Payment must be made upon receipt of supplies.

_____ _____/_____/_____
Patient Signature Date

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and hereby release you of any consequence thereof.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collection counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at anytime, I agree to notify the office immediately.

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Staff Signature Date

1

MUSCULO-SKELETAL - fill out a different numbered section for each injury area (for example, neck - section #1, back - section #2, leg - section #3, etc.)

{please fill out each section with only information related to that body part }

#1 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

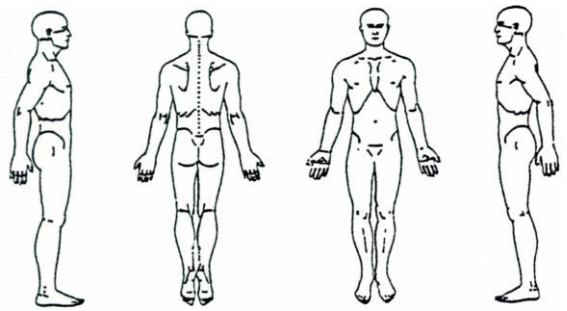
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#2 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

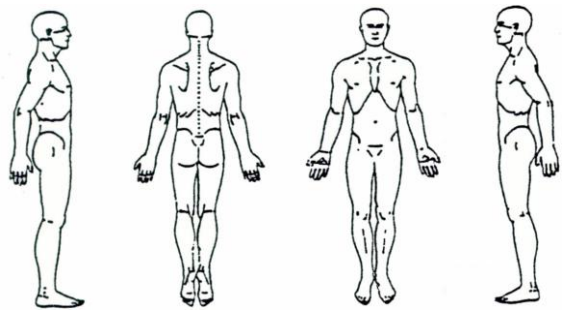
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

CHCC Name: _____ Date: _____ Signature: _____

1

MUSCULO-SKELETAL - fill out a different numbered section for each injury area (for example, neck - section #1, back - section #2, leg - section #3, etc.)

{please fill out each section with only information related to that body part }

#3 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

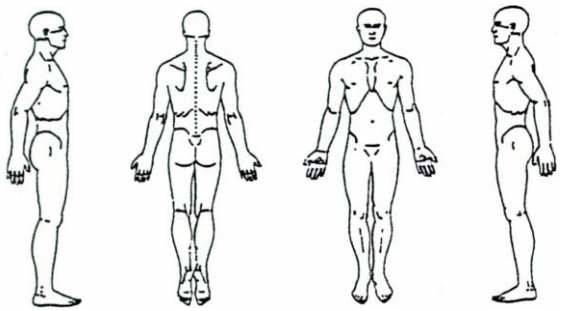
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#4 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse?❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

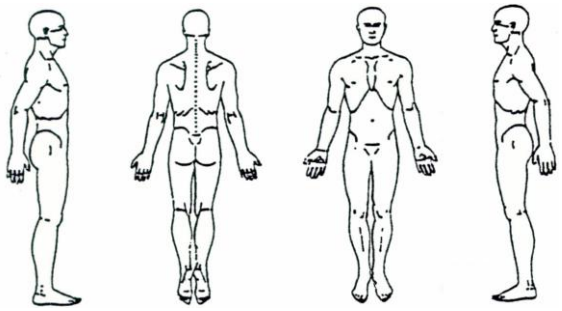
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

2 CURRENT HEALTH CONDITION

The previous section had you document STRUCTURAL pains that you may be experiencing. This section allows you to document ORGAN dysfunctions you may be experiencing. Some examples include be are not limited to:

Fatigue	**Diarrhea**	**Bladder Issues**
Loss of Sleep	**Constipation**	**Painful/Excess Urination**
Allergies	**Colitis**	**High Blood Pressure**
Nasal Congestion	**Heartburn**	**Ankle Swelling**
Headaches	**Frequent Nausea**	**Vision Problems**
Cold/Tingling Extremities	**Gas/Bloating After Meals**	**Hearing Difficulties**
Dizziness	**Gall Bladder Problems**	**Menstrual Cramps**
Numbness	**Acid Reflux**	**Heart Problems**

Primary Unwanted Health Condition _____

_____

_____

_____

2nd Unwanted Health Condition _____

_____

_____

_____

3rd Unwanted Health Condition _____

_____

_____

_____

4th Unwanted Health Condition _____

_____

_____

_____

_____

3 Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	DOCTOR'S COMMENTS
GENERAL		
Have you ever had an adverse reaction to or following chiropractic care?	❒	
BONE WEAKNESS		
Have you ever been diagnosed with osteoporosis?	❒	
Do you take corticosteroids? (e.g. prednisone)?	❒	
Have you been diagnosed with a compression fracture(s) of the spine?	❒	
Have you ever been diagnosed with cancer?	❒	
Do you have any metal implants?	❒	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	❒	
If yes, about how much do you take daily? _____	❒	
Do you take warfarin (coumadin), heparin or other similar "blood thinners"?	❒	
Have you ever been diagnosed with any of the following disorders/diseases?	❒	
• Reumatoid arthritis	❒	
• Reiter's syndrome, ankylosing spondylitis or psoriatic arthritis	❒	
• Giant cell arteritis (temporal arteritis)	❒	
• Osteogenesis imperfecta	❒	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	❒	
• Medial cystic necrosis (cystic mucuoid degeneration)	❒	
• Bechet's disease	❒	
• Fibromuscular dysplasia	❒	
Have you ever become dizzy or lost consciousness when turning your head?	❒	
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	❒	
If yes when? _____	❒	
Have you been diagnosed with spinal stenosis?	❒	
Have you been diagnosed with spondylolisthesis?	❒	
Have you had any of the following problems?	❒	
• Sudden weakness in the arms or legs?	❒	
• Numbness in the genital area?	❒	
• Recent inability to urinate or lack of control when urinating?	❒	

HEALTH HISTORY – ***Please check the box(es) on the LEFT SIDE of the table that pertains to YOU; check the box(es) on the RIGHT SIDE of the page that pertains to your FAMILY MEMBERS (mother, father, sister, brother, cousin, aunt uncle, grandmother, etc.). If you have additional treatments, please write them on the back with the corresponding number (ex., put on back 8. Asthma – Proventil and Respirtone).***

4

	YOUR HEALTH HISTORY				FAMILY HEALTH HISTORY		
	Ailments	Surgery Date	Age	Treatment	Relation	Deceased (Yes/No)	Age of Death
1	❑AIDS/HIV					Yes / No	
2	❑Alcoholism					Yes / No	
3	❑Allergy Shots					Yes / No	
4	❑Anemia					Yes / No	
5	❑Anorexia					Yes / No	
6	❑Appendicitis					Yes / No	
7	❑Arthritis					Yes / No	
8	❑Asthma					Yes / No	
9	❑Bleeding Disorders					Yes / No	
10	❑Breast Lump					Yes / No	
11	❑Bronchitis					Yes / No	
12	❑Bulimia					Yes / No	
13	❑Cancer					Yes / No	
14	❑Cataracts					Yes / No	
15	❑Chemical Dependency					Yes / No	
16	❑Chicken Pox					Yes / No	
17	❑Cyst					Yes / No	
18	❑Depression					Yes / No	
19	❑Diabetes					Yes / No	
20	❑Eczema					Yes / No	
21	❑Emphysema					Yes / No	
22	❑Epilepsy					Yes / No	
23	❑Gallstones					Yes / No	
24	❑Genital Warts					Yes / No	
25	❑German Measles/Rubella					Yes / No	
26	❑Glaucoma					Yes / No	
27	❑Goiter					Yes / No	
28	❑Gonorrhea					Yes / No	
29	❑Gout					Yes / No	
30	❑Heart Disease					Yes / No	
31	❑Hemorrhoid					Yes / No	
32	❑Hepatitis A					Yes / No	
33	❑Hepatitis B					Yes / No	
34	❑Hepatitis C					Yes / No	
35	❑Hernia					Yes / No	
36	❑Herniated Disc					Yes / No	
37	❑Herpes					Yes / No	
38	❑High Blood Pressure					Yes / No	
39	❑High Cholesterol					Yes / No	
40	❑Hysterectomy					Yes / No	
41	❑Kidney Disease					Yes / No	

5

4

	YOUR HEALTH HISTORY				FAMILY HEALTH HISTORY			**5**
	Ailments	**Surgery Date**	**Age**	**Treatment**	**Relation**	**Deceased (Yes/No)**	**Age of Death**	
42	❑Liver Disease					Yes / No		
43	❑Lung Problems					Yes / No		
44	❑Lupus					Yes / No		
45	❑Measles					Yes / No		
46	❑Mental Disorder					Yes / No		
47	❑Migraine Headaches					Yes / No		
48	❑Miscarriage					Yes / No		
49	❑Mononucleosis					Yes / No		
50	❑Multiple Sclerosis					Yes / No		
51	❑Mumps					Yes / No		
52	❑Osteoporosis					Yes / No		
53	❑Other					Yes / No		
54	❑Pacemaker					Yes / No		
55	❑Parkinson's Disease					Yes / No		
56	❑Pinched Nerve					Yes / No		
57	❑Pleurisy					Yes / No		
58	❑Pneumonia					Yes / No		
59	❑Polio					Yes / No		
60	❑Prostate Problems					Yes / No		
61	❑Prosthesis					Yes / No		
62	❑Psychiatric Care					Yes / No		
63	❑Rheumatic Fever					Yes / No		
64	❑Rheumatoid Arthritis					Yes / No		
65	❑Scarlet Fever					Yes / No		
66	❑Small Pox					Yes / No		
67	❑Spinal					Yes / No		
68	❑Stroke					Yes / No		
69	❑Suicide Attempt					Yes / No		
70	❑Thyroid Problems					Yes / No		
71	❑Tonsillitis					Yes / No		
72	❑Tuberculosis					Yes / No		
73	❑Tumors, Growths					Yes / No		
74	❑Typhoid Fever					Yes / No		
75	❑Ulcers					Yes / No		
76	❑Vaginal Infections					Yes / No		
77	❑Venereal Disease					Yes / No		
78	❑Whooping Cough					Yes / No		
						Yes / No		
	Other					Yes / No		
	❑_____					Yes / No		
	❑_____					Yes / No		
	❑_____					Yes / No		
	❑_____					Yes / No		
	❑_____					Yes / No		

6

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Hernia ❑ Back Surgery

❑ Broken Bones ❑ Other ____________________

Major Accident of Falls: ____________________

____

Hospitalization (Other Than Above): ____________________

____

Previous Chiropractic Care: ❑ None ❑ Doctor's Name & Approximate Date of Last Visit ____________________

A. ❑ Have you ever had chiropractic care for other problems? ❑ Yes ❑ No If yes, when? ____________________

❑ Do you take: ❑ Muscle Relaxers ❑ Pain killers ❑ Over-the-counter medications

B. ❑ Do you have a permanent disability rating? ❑ Yes ❑ No If yes, location: ____________________

Date received the rating: ____________________ Rating percentage: ____________

C. ❑ List fractures, dislocations, concussions, falls (head injuries, car accidents, fender benders, gym injuries, horses, etc.)

Date	Description	Treatment

7 MISCELLANEOUS

EXERCISE	WORK ACTIVITY	HABITS	
❑ None ❑ Moderate ❑ Daily ❑ Heavy	❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor ❑ Computer Work	❑ Smoking ❑ Alcohol ❑ Drug (Recreational) ❑ Coffee/Caffeine Drinks ❑ High Stress Level	Packs/Day _____ Drinks/Week_____ Times/Week _____ Cups/Day _____ Reason _____

8 CHIROPRACTIC HEALTH QUESTIONNAIRE

❑ Other prescription drugs: _____

Sleep _____ hrs/night Do you sleep on your: ❑ Back ❑ Side ❑ Stomach
Age of mattress _____ or waterbed _____ Is your bed comfortable? ❑ No ❑ Yes
What kind of pillow do you use? ❑ Thick ❑ Medium ❑ Thin ❑ None ❑ Support Age of pillow: _____
Do you wear: ❑ Heel lifts ❑ Shoe lifts ❑ Arch supports ❑ Orthotics, describe _____

9 CARE

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). 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 guidd by your wishes whenever possible.

❑ Relief Care ❑ Corrective Care ❑ Check here if you want the Doctor to select the type of care appropriate for your condition

_____ _____

Date Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

10 CHCC AGREEMENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I agree to notify this doctor immediately whenever I have changes in my health condition(s) in the future.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collections counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at any time, I agree to notify the office immediately.

_____ ___/___/___
Patient Signature Date

_____ ___/___/___
Parent or Guardian Signature (if patient is minor) Date

_____ ___/___/___
Staff Signature Date