Please check the correct box for each item below.
Check at least one box for each sign or symptom listed.

Never Present Previous

GENERAL SYMPTOMS

☐☐☐ 905.3 Allergy (What) _____
☐☐☐ 780.4 Dizziness
☐☐☐ 780.2 Fainting
☐☐☐ 780.7 Fatigue
☐☐☐ 784.0 Headache
☐☐☐ 787.0 Nausea
☐☐☐ 729.2 Neuralgia
☐☐☐ 782 Numbness/pain in arms/legs/hands

SKIN OR ALLERGIES

☐☐☐ 924.9 Bruising Easily
☐☐☐ 691.8 Eczema
☐☐☐ 708.9 Hives or Allergy
☐☐☐ 782.0 Sensitive Skin

GASTRO-INTESTINAL

☐☐☐ 789.0 Colon Trouble
☐☐☐ 575.9 Gall Bladder Trouble
☐☐☐ 455.6 Hemorrhoids (piles)
☐☐☐ 794.8 Liver Trouble
☐☐☐ 536.8 Pain over Stomach

EYE/EAR/NOSE/THROAT

☐☐☐ 493.9 Asthma
☐☐☐ 389.9 Deafness
☐☐☐ 784.7 Nose Bleeds
☐☐☐ 379.91 Pain in Eyes

RESPIRATORY

☐☐☐ 786.50 Chest Pain
☐☐☐ 786.09 Difficulty Breathing
☐☐☐ 786.3 Spitting Blood

Never Present Previous

MUSCLES & JOINTS

☐☐☐ 550.0 Hernia
☐☐☐ 719.1 Pain Between Shoulders
☐☐☐ 724.6 Painful Tailbone
☐☐☐ 781.9 Spinal Curvature
☐☐☐ 719.0 Swollen Joints
☐☐☐ 781.0 Tremors
☐☐☐ 781.0 Twitching

CARDIO-VASCULAR

☐☐☐ 401.9 High Blood Pressure
☐☐☐ 458.9 Low Blood Pressure
☐☐☐ 786.51 Pain over Heart
☐☐☐ 438 Past Heart Trouble
☐☐☐ 436 Strokes
☐☐☐ 782.3 Ankle Swelling

GENITO-URINARY

☐☐☐ 599.7 Blood in Urine
☐☐☐ 788.4 Frequent Urination
☐☐☐ 788.3 Inability to Control Urine
☐☐☐ 590.9 Kidney Infection
☐☐☐ 788.1 Painful Urination
☐☐☐ 601.9 Prostate Problems

FOR WOMEN ONLY

☐☐☐ 625.3 Cramps or Backaches
☐☐☐ 627.2 Hot Flashes
☐☐☐ 626.4 Irregular Cycle
☐ Yes ☐ No Currently Pregnant
_____ Due Date
_____ Last Pap Date

History of Current Complaint:

Prior operations and procedures: _____

_____

Prior Treatment for current complaints? ☐ Yes ☐ No When? _____ By Whom? _____

Type and Results? _____

List any accidents or falls and dates: ☐ Car: _____ ☐ Recreation Vehicle: _____

☐ Sports: _____ ☐ School: _____ ☐ Other: _____

List any broken bones (fractures) or dislocations: _____

Have you ever had any spinal injections (e.g. facet or epidural injection)? ☐ Yes ☐ No When: _____

What type: _____

Have you ever had X-rays / MRI's? ☐ Yes ☐ No When? _____ By Whom? _____

What were the findings? _____

Are you presently taking any medication – prescription or over the counter? ☐ No ☐ Yes What drugs? _____

_____

What are your goals or expectations for your treatment (e.g. decreased pain, increased function, etc.)? _____

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account or receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is 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 HAVE READ AND UNDERSTAND THE ABOVE

Patient's/Guardian's Signature: _____ Date: _____

903 Embarcadero Drive, Suite 4 ▪ El Dorado Hills, CA 95762
916.933.9870 (office) ▪ 916.933.3540 (fax)

NorCal Spine & Sport
CHIROPRACTIC & SPORTS THERAPY

PATIENT HISTORY

Date: _____

Name: _____ Phone (Home): _____

Address: _____ Phone (Work): _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Email: _____

Social Security Number: _____ Appointment reminder preference: Call ☐ Email ☐ Text ☐

Sex: ☐ M ☐ F Marital Status: S ☐ M ☐ D ☐ W ☐ Spouse's Name: _____

# of Children: _____ Spouse's Occupation: _____

Referred by: _____ Spouse's Employer: _____

Doctor's Name: _____ Spouse's Phone (Cell/Work): _____

Employer: _____ Past Chiropractic/Physical Therapy Care: ☐ Yes ☐ No

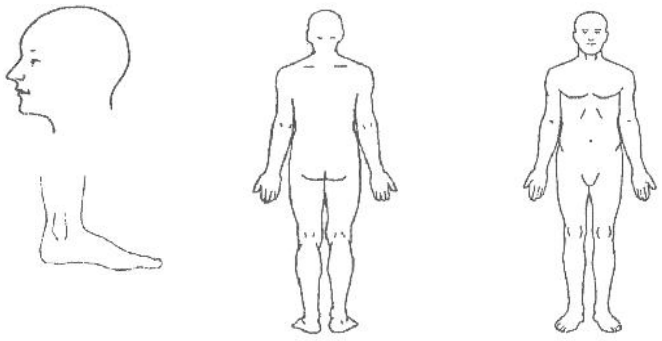
Occupation (Part or Full): _____ Results: _____

Chief Complaint / List Current Problems

1. _____ Duration (How Long): _____ Previous Episodes: _____
2. _____ Duration (How Long): _____ Previous Episodes: _____
3. _____ Duration (How Long): _____ Previous Episodes: _____

Please mark area and type of pain on the drawings using the codes listed below.

Pain = **P**	Numbness = **N**
Stiffness = **ST**	Tingling = **T**
Ache = **A**	Soreness = **S**
Sharp = **SH**	Burning = **B**



BP: L _____ / _____ **R** _____ / _____

Pulse: ____ /min **Ht:** ____' ____" **Wt:** _____ lbs.

HABITS

☐Smoking Packs/Day: _____

day:_____

☐Drinking Alcohol: _____

☐Coffee Cups/Day: _____

☐High Stress Reason: _____

EXERCISE

☐None

☐Moderate

☐Daily

Type: _____

NUTRITION

☐Water Intake Liters or Ounces per

☐Vitamin/Mineral Supplements: _____

_____

☐How important is your health?

Least 1 2 3 4 5 6 7 8 9 10 Most

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐ 280 Anemia ☐ 345 Epilepsy

☐ 044 HIV Positive ☐ 250 Diabetes

☐ 319 Mental Disorder _____

☐ 239 Cancer _____

☐ 429.9 Heart Disease _____

☐ Other: _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, # ___	☐	☐	☐	☐	☐
Sister, # ____	☐	☐	☐	☐	☐

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