Personal Health History

Date:_____ Name:_____ Spouse's name:_____

Address:_____

City:_____ State:_____ Zip:_____CA Driver's License #:_____

Home phone:_____ Cell Phone: _____ Birthdate:_____ Age:_____

Business/Employer:_____Type of work:_____

Sex: M F Check one: ☐ Single ☐ Married ☐ Divorced ☐ Separated Number of children_____

Name of parent if minor:_____Phone #:_____

Referred by:_____ **Email Address:** _____

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Worker's Comp. ☐ Medicare ☐ Auto insurance

☐ Personal Health insurance Other_____

Method of Payment for Initial Visit Charges: ☐ Cash ☐ Check ☐ Visa ☐ MC

Name of Insurance co.:_____Social Security #:_____

Phone # of Insurance co.:_____ Your policy #_____

Name policy is under:_____Place of Employment_____

Are you here for a Scoliosis or Free spinal exam? ☐ Yes ☐ No

Purpose of this Appointment::_____

_____

Other Doctors seen for this condition:_____

When did this condition begin:_____Is it ☐ Job related ☐ Auto related ☐ home accident

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ Blood pressure pills ☐ Insulin

☐ Other_____ Women only: Are you pregnant? ☐ Yes ☐ No

Major surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Spinal_____

☐ Broken Bones ☐ Other:_____

Major Accidents or falls:_____

Hospitalizations (other than above):_____

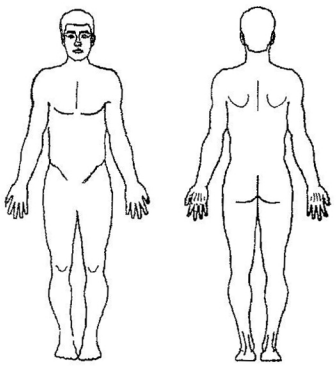
Previous Chiropractic care: ☐ No ☐ Yes: where/when_____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐ Other_____

☐ Hip Pain ☐ Arm / Leg Pain ☐ Numbness



Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Allergies _____
Asthma _____
☐ Tobacco Use - Type_____
Frequency_____/Day

Informed Consent for chiropractic care

I do hereby authorize Dr. Earl Shaw or another Chiropractor appointed by him to administer such treatment that is necessary for my case. This treatment may include consultation, examination, adjustments, or any other procedure necessary for my care. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I also understand that I am responsible for any unpaid balance from assignment by my insurance company.

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is very minimal, yet in very rare cases injury has been associated with chiropractic care. Some types of complications secondary to chiropractic care have included sprain/strain, irritation to disc conditions, and rarely fractures. And in extremely rare cases there have been reported cases of stroke associated with visits to medical doctors and chiropractors.

Prior to receiving chiropractic care in this office, a heath history and examination will be completed. These procedures will assist us in determining your over all health, specific condition, spinal health, and if chiropractic care or another form of health care is needed for your case. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

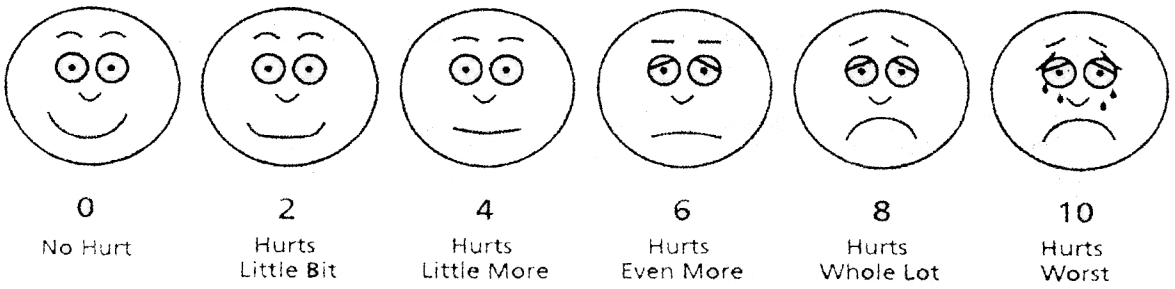
I _____, have read, understand and request care based on the above agreement.

Date: _____ Signature: _____

Signature of parent or guardian if minor: _____

My signature also acknowledges that I have received a copy of my HIPPA privacy notice

Pain Questionnaire



Please Circle which best describes how your typical level of pain affects these six categories of activities.

1. Family / at home responsibilities such as yard work, chores around the house or driving the kids

1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

2. Recreation including hobbies, sports or other leisure activities.

1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

3. Social activities including parties, theater, concerts, dining-out and attending other social functions

1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

4. Employment including volunteer work and homemaking tasks

1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

5. Self-care such as taking a shower, driving or getting dressed

1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

6. Life-support activities such as eating and sleeping

1 2 3 4 5 6 7 8 9 10

completely able to function — totally unable to function

Patient Signature _____ Date_____