

MODESTO CHIROPRACTIC CENTER-INITIAL HEALTH STATUS

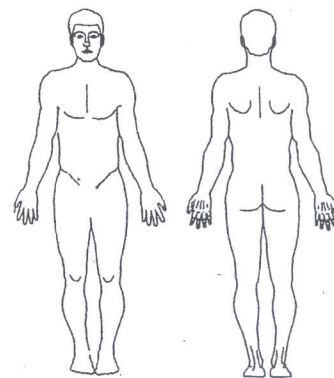
X-Ray: _____

Patient Name: _____ Birthdate: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Ph: _____ Cell Ph: _____ SSN #: _____ Driver Lic#: _____
 Sex: M F Height _____ Weight _____ Marital Status: _____ Kids: _____ Referred By: _____
 Occupation: _____ Employer: _____ Work Phone: _____
 Spouse Name: _____ Employer: _____

DATE INJURY/PROBLEM BEGAN: _____ Emergency Contact Name & #: _____

DESCRIBE HOW IT BEGAN:

MARK AN X WHERE YOU HAVE PAIN



Is this? Work Related Auto Related N/A

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? 0 – 25% 26 – 50% 51 – 75% 76 – 100%
 Can you perform your daily activities? Yes No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: None Apply

- | No | Yes | Condition | No | Yes | Condition |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____ | <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks | <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention | <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma | | | |

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

Are you Insured? Yes No Company _____

Insured's name if patient is a dependant _____ Insured Soc. Sec. No. _____

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I hereby give my authorization to release any of my medical records which are deemed pertinent and power of attorney to endorse checks made out to me, to be credited to my account.

Patient Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____