Almaden Chiropractic & Wellness 5570 Sanchez Drive, Ste 100, San Jose, CA 95123 408-262-7111

Name_____ Date of Birth_____ Age_____

Address_____ City_____ State_____ Zip_____

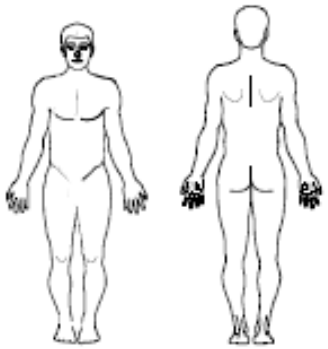
Cell Phone_____ E-Mail Address_____

Employer_____ Job Title_____

Are you pregnant? _____ How were you referred to our office? _____

Emergency Contact, Name and Phone #:

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

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

☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

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? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

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

In general would you say your overall health right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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

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

What makes it better? _____ What makes it worse? _____

What Doctors have you seen for this? _____

What type of treatment was recommended? _____

Results? _____

On a scale of 1-10, how committed are you to correcting this issue? _____

List any medications you are taking: _____

List any doctors you are currently seeing: _____

Has any Doctor or other professional advised you to see a chiropractor? _____

List past auto accidents: _____ Was care received? _____

List past work injuries: _____ Was care received? _____

List past sport, recreational or home injuries: _____

List any past conditions and treatments: _____

List any surgeries: _____

Family History: Cancer: __ Diabetes: __ High Blood Pressure: __ Heart Problems/Stroke: __ Arthritis: __

Health History:

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Sinus Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	Painful Menstruation
❑	❑	Muscle Aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Low energy
❑	❑	Arm / Hand Numbness	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Neck Pain
❑	❑	Vision Problems	❑	❑	Middle Back Pain
❑	❑	Thyroid Problems	❑	❑	Lower Back Pain
❑	❑	Liver Disease	❑	❑	Tension / Irritability
❑	❑	Kidney Problems	❑	❑	Chest Pains
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

Subscriber Name_____ Health Plan_____

Subscriber ID# _____Group # _____ Spouse Name _____

Spouse Employer _____ Address _____

Primary Care Physician Name _____ PCP Phone _____

I certify to the best of my knowledge 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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician if necessary.

Patient Signature _____ Today's Date _____