LIFE CHIROPRACTIC HEALTH CENTER

Dr. Dominique M. Scott, D.C.

Name _____ Address _____

City _____ State _____ Zip _____ Primary E-mail _____

Home phn _____ Cell phn _____

SSN _____ Date of birth _____ Age _____ Height _____ Weight _____

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ # of children _____ Name of spouse (or parent) _____

How were you referred to our office? _____

Occupation_____ Employer Name_____

Employer Address_____ _____City _____ State____ Zip ____ ____ Wk phn _____

Have you ever had Chiropractic care before? ____If yes, when? _____

Please list your chief complaints in order of severity (pain, discomfort, symptoms, etc.), and any other health issues

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

Name of family physician _____

Do you ever experience any of these complaints while working? _____ If yes, describe what activities at work that may be causing you to experience these complaints: _____

_____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____ If yes, please explain: _____

If this is due to an injury or accident, what is the date of injury or accident? _____

Has this problem been getting better, worse, or staying the same? _____

What activities make your condition worse? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any injuries or illnesses that you have had that are not listed above: _____

Please indicate medications (over the counter) / prescriptions you are currently taking: ☐ Aspirin/Tylenol ☐Pain killers ☐Muscle Relaxers ☐Insulin ☐Tranquilizers ☐Birth Control Pills ☐Others _____

Have you been involved in an auto accident in the last 12 months? _____ If yes, when? _____

Health Insurance (i.e. Anthem, Blue Cross, Medicare, etc) _____

Name of **Primary** Policy Holder_____ Primary Policy Holder's Date of Birth _____

Primary Policy Holder's Relationship to patient (please circle one): *self spouse parent other (please specify)*_____

Secondary health insurance (if applicable)_____

Policy Holder's Name, Relationship, Date of Birth (if different from above) _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.
0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

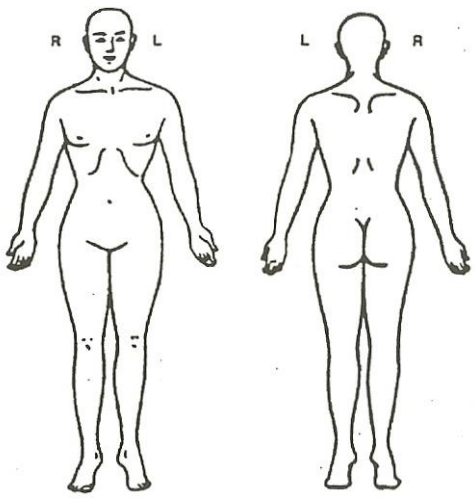
0 1 2 3 4 5 6 7 8 9 10

Completely Comfortable and Functional — Severe discomfort and/or unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____
2. RECREATION: hobbies, sports, and other similar leisure time activities. _____
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

MARK DIAGRAMS BELOW with the location of your pain, discomfort or any other health problems. Also describe the type and when it occurs. (dull, sharp, deep, tight, on/off, with bending, sitting, standing etc)

Use the 0 – 10 scales to rate the condition (pain or loss of function) at its recent worst case.
Use a different scale for each appropriate region.



HEAD/NECK
0 1 2 3 4 5 6 7 8 9 10

UPPER BACK
0 1 2 3 4 5 6 7 8 9 10

LOW BACK
0 1 2 3 4 5 6 7 8 9 10

OTHER: _____
0 1 2 3 4 5 6 7 8 9 10

Method of payment for today's charges: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature _____ **Date**_____

Health Survey

Please rate each condition below with one of the appropriate following symbols X presently have ✓ previously had — never had.

Gastrointestinal

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble

Nervous System

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

Cardiovascular

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose veins

Eye, Ear, Nose and Throat

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Hearing loss
_____ Ear discharge
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

Musculoskeletal

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

Genitourinary

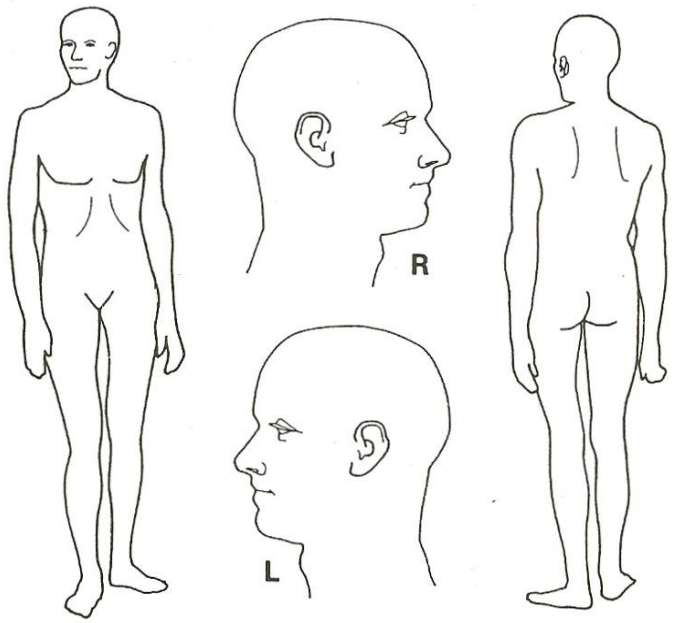
_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

Female

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant
_____ Yes _____ No

Mark areas of pain resulting from this accident on figures below



Patient's signature
(If a minor, parent's or guardian's signature _____ Date _____

Office Use *(Do not write below here)*

Doctor's signature _____ Date _____