6530 Highway 9, Felton, CA. 95018 (831) 335-9300 feltonfamilywellness@yahoo.com feltonchiro.com

Confidential Patient Information

- Are you receiving Workers' Compensation (WC) benefits? Yes No
- Are you filing a claim with a no-fault insurance or liability insurance? Yes No
- Are you being treated for an injury or illness for which another party has been found responsible? Yes No

Today's Date____/____/_____ **Title** (circle one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name_____ **Nickname**_____

Last Name_____

Address_____

City_____ **State**_____ **Zip Code** _____

Date of Birth____/____/_____ **Gender** M F Unspecified

SSN/Medicare Number_____-_____-_____

Marital Status (circle one) Single Committed Married Divorced Widowed

Spouse's Name_____

Race (circle any that apply)

Caucasian	American Indian/Alaskan	Pacific Islander
Asian	Black	Other_____
African American	Native Hawaiian	

Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino

Preferred Language (circle one)

English	French	Portuguese
Spanish	German	Other_____

Phone Numbers 1) Home_____ 2) Cell_____ 3) Work_____

What phone number is best to contact you? (circle one) Home Cell Work

Email address_____

Medical Doctor's Name_____

Employer_____

Occupation_____ Full Time Part Time

Smoking Status (circle one) Current Every Day Smoker Current Sometimes Smoker

Former Smoker Never Been A Smoker

Height ___'___" **Weight** _____

Who referred you to us?_____

How else did you hear about us? _____

Health History

Past History

Have you had any major illnesses in the past?_____

_____

Do you have any current medical conditions?

_____

Have you had any injuries?_____

_____

Have you been hospitalized?_____

Have you had any surgeries?_____

Medications List any medications that you are taking, including dosage and frequency.

If no medication check here___

1)_____ 5) _____

2)_____ 6) _____

3)_____ 7) _____

4)_____ 8) _____

Allergies Please list any allergies below, including allergies to medications.

If no allergies , check here___

1)_____ 3)_____

2)_____ 4) _____

Main Problem

What complaint causes you to come to the office?_____

What caused this condition?_____

When did this condition start? _____ How long does this pain last? _____

How bad is this pain? (Circle the one that applies) Mild Moderate Severe Intolerable

Rate your pain (0=No pain 10=worst pain imaginable) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightening-like, Throbbing, Nagging, Burning, Deep, Stinging, Pressure-like

How often does the pain occur? (Circle the one that applies) Occasional Frequent Constant

Does this pain travel to any other area?_____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Other Problem (If applicable)

What other complaint do you have? _____

What caused this condition?_____

When did this condition start? _____ How long does this pain last? _____

How bad is this pain? (Circle the one that applies) Mild Moderate Severe Intolerable

Rate your pain (0=No pain 10=worst pain imaginable) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightening-like, Throbbing, Nagging, Burning, Deep, Stinging, Pressure-like

How often does the pain occur? (Circle the one that applies) Occasional Frequent Constant

Does this pain travel to any other area?_____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

SYMPTOMS Mark the areas of your symptoms on the figure to the right.

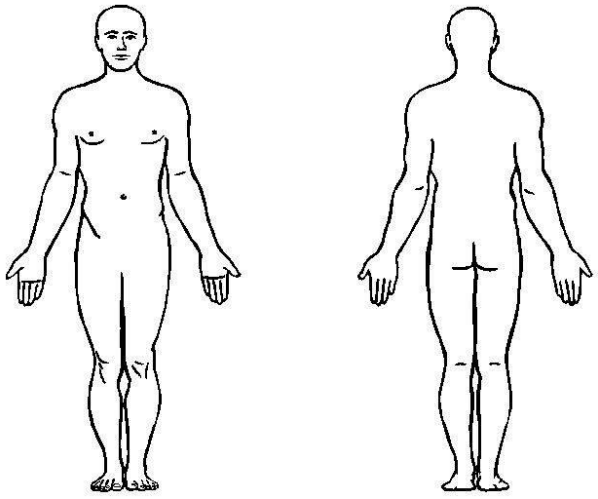
Use the following symbols:

Aches ^^^^

Numbness **oooo**

Pins/Needles ····

Stabbing ////



Family History

Please tell us about the health of you grandparents, parents, and siblings. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

	Living **D**eceased	Heart disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease
Maternal Grandmother	**L D** Cause							
Maternal Grandfather	**L D** Cause							
Paternal Grandmother	**L D** Cause							
Paternal Grandfather	**L D** Cause							
Father	**L D** Cause							
Mother	**L D** Cause							
Sibling M F	**L D** Cause							
Sibling M F	**L D** Cause							
Sibling M F	**L D** Cause							
Sibling M F	**L D** Cause							
Other relative	**L D** Cause							

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signed_____

Date_____