HEALTHWORKS CHIROPRACTIC
182 S. Main St. Milpitas, CA 95035
PH: 408.262.7000 FAX: 408.262.7002

Referred By________________

PATIENT INFORMATION

Name ______________________ Birth Date:__________ Age:______ Sex: M / F

Address: ______________________ City:__________ State:______ Zip:________

Home Phone:______________ Work Phone: ______________ Cell Phone: ______________

Driver's License #:______________ Social Security #: ______________ Marital Status:__________

Occupation:______________ Employer:______________ Years Employed: ________

In Case of Emergency, Please Contact______________ Phone:__________Relation:__________

Please fill out insurance info, if applicable and hand insurance card to receptionist to copy.

Name of insured:______________ Insurance Company:______________ Phone: __________

Policy #:______________ Group #:______________ Member #:______________ Cert #:________

Agent______________ Medicare #: ______________

Reason For Today's Visit:____

Please Briefly Describe What Happened:____

____

How long have you had this condition?__________ Have you had this or a similar condition in the past?:__________

What aggravates this condition?:____

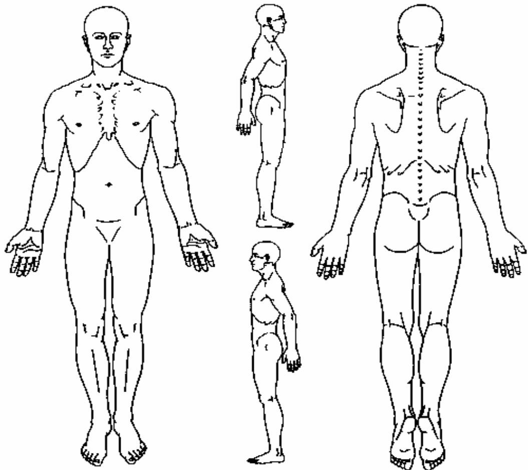
Is this condition getting progressively worse? ☐ YES ☐ NO ☐ Constant ☐ Comes & Goes

Are you seeing other Doctors for this condition?______ Length of time under care________ Did it help?:__________

Doctor Name:______________ Address:______________ Phone #: ______________

Type of Doctor: ______________(ie. Neurologist, Orthopedist, etc.) Any Physical Therapy?__________

ON THE DIAGRAM BELOW, PLEASE INDICATE WHERE YOU ARE EXPERIENCING PAIN OR OTHER SYMPTOMS. A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing O=Other



Please indicate level of pain by marking on the scale below:

Have you seen a Chiropractor before______________

What type of treatment did you receive?:______________

____

What did you like?______________________

____

What did you dislike?______________________

____

List Current Medications Taken:____

List Current Non-Prescription Drugs/Vitamins Taken:______________________________

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediatly due and payable.

Patient Signature:______________________ Date: ______________ Staff Initial:__________

IMPORTANT: Please check (X) all present symptoms.

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HEAD:

Headache
- ☐ sinus (allergy)
- ☐ entire head
- ☐ back of head
- ☐ forehead
- ☐ temples
- ☐ **migraine**

- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-Headedness
- ☐ Fainting
- ☐ Light bother eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ forward
  - ☐ backward
  - ☐ turn to lett
  - ☐ turn to right
  - ☐ bend to left
  - ☐ bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

ARMS AND HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins and needles in arms
- ☐ Sensation of pins and needles in fingers
- ☐ Numbness in arms (R-L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R- L)
- ☐ Muscle spasms in shoulders

MID BACK:
- ☐ Mid-back pain
- ☐ Location ____________
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat ____________
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
- ☐ Upper lumbar
- ☐ Lower lumbar
- ☐ Sacroiliac
- ☐ Low back pain is worse when:
- ☐ Working
- ☐ Lifting
- ☐ Stooping
- ☐ Standing
- ☐ Sitting
- ☐ Bending
- ☐ Coughing
- ☐ Lying down (sleeping)
- ☐ Walking
- ☐ Pain relieved when ____________
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIP, LEGS, AND FEET:
- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Pain down leg
- ☐ Pain down both legs
- ☐ Knee pain
  - ☐ inside
  - ☐ outside
- ☐ Leg cramps
- ☐ Cramps in feet
- ☐ Pins and needles in legs
- ☐ Numbness of leg
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles
- ☐ Swollen feet

WOMEN ONLY:
- ☐ Menstrual pain ____________(where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle ____________ days
- ☐ Birth control ____________ (type)
- ☐ Hysterectomy
- ☐ Genital cancer ____________
- ☐ Discharge
- ☐ Menopause
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:
- ☐ Urinary frequency ____________
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostrate pain/swelling

GENERAL
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep ____________hrs/night
- ☐ Loss of sleep ____________ hrs/night
- ☐ Loss of weight ____________ lbs
- ☐ Gain weight ____________ lbs
- ☐ Coffee ____________ cups/day
- ☐ Tea ____________ cups/day
- ☐ Cigarettes ____________ pack/day
- ☐ Other ____________
- ☐ Diabetes
- ☐ Hypoglycemia

List any Surgeries below:

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Patient's Initial: ____________ Date ____________