Welcome to Stevens Creek Chiropractic

Name:_____Date:_____
Address:_____City:_____
State:_____Zip:_____Phone 1:_____Phone 2:_____
Email:_____Date of Birth:_____
Occupation:_____Employer:_____Referred By:_____
Marital Status: S M D W Spouse Name:_____Children? Y N #_____

HEALTH HISTORY:

Age:_____ Height:_____ Weight:_____

Drugs, Prescription, OTC?	**Y N**
Surgeries? Hospitalizations?	**Y N**
Injuries During Sports?	**Y N**
Auto Accidents?	**Y N**
Other Old Traumas?	**Y N**
Did You Ever Break Any Bones?	**Y N**
Diseases/Disabilities?	**Y N**
Significant Family Medical History?	**Y N**

Please Explain Any/All **Yes** Answers:

_____

_____

CURRENT HEALTH HABITS:

Sports/Exercise Regularly?	**Y N**
Did/Do You Smoke?	**Y N**
Did/Do You Drink Alcohol?	**Y N**
Diet, Do You Eat Healthy Foods?	**Y N**
Dental/Eye/Ear Problems?	**Y N**
Sinus/Breathing Problems?	**Y N**
Digestive Problems?	**Y N**
Do You Have Occupational Stress?	**Y N**
Drive? Daily Time Spent Driving?	**Y N**
Physical/Mental/Emotional Stress	**Y N**
Hobbies?	**Y N**

Do You Sleep Well? **Y N** # of Hrs:_____
Sleep on: Back / Side / Stomach

_____

_____

Female: Pregnant Y N Date of last Menstruation:_____ □Menstrual Cramps □Menopause
Have you had previous Chiropractic Care?_____
PRESENT COMPLAINT/Reason for seeking care in this office:_____

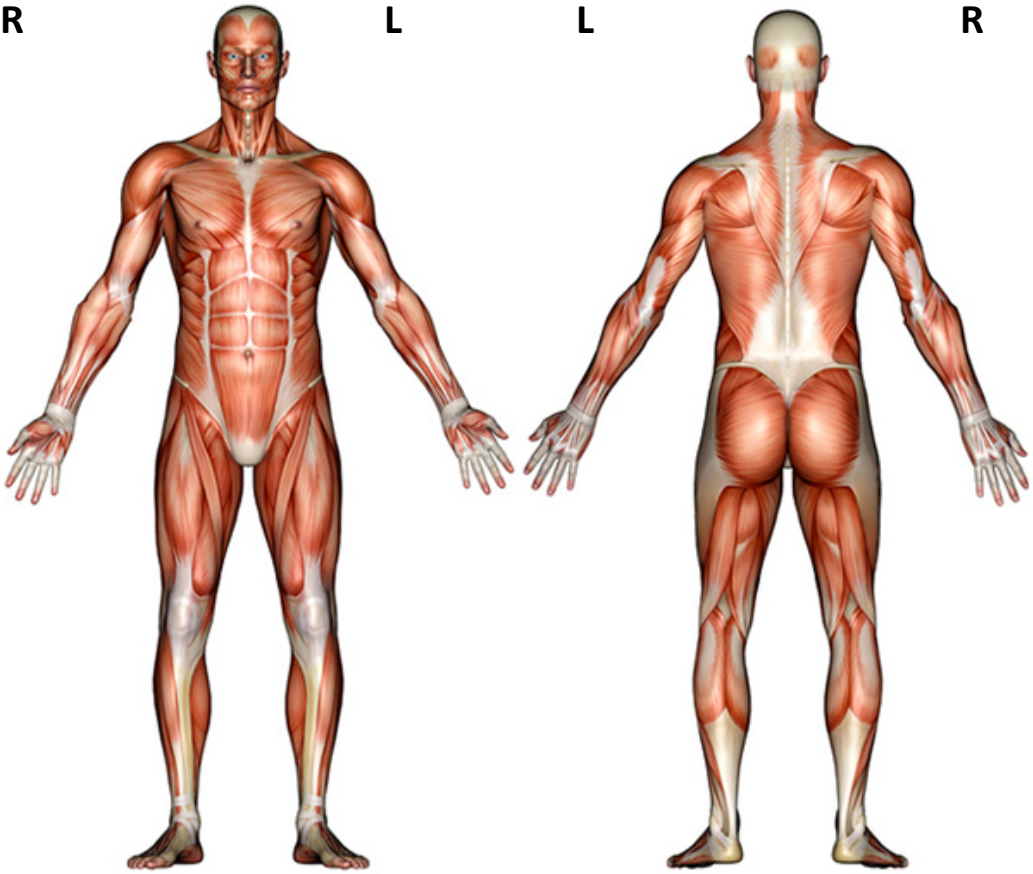
_____

When did it start?_____What Happened?_____
Pain is: □ Sharp □ Dull/Ache □ Shooting □ Specific □ Constant □ Comes & Goes □ Numb □Tingling
Since it Began, is it: □ Same □ Slightly Improved □ Much Improved □ Worse □ Progressively Worse
What activities make it worse?_____
What activities make it better?_____
Is this condition better or worse at certain times of the day?_____
What is your current level of pain, on a scale of 1 to 10 with 10 being the worst:_____
Also rate level of pain during: Self Care_____ Work_____ Home Care_____ Hobbies_____ Social Life_____
Explain:_____
Have you seen a health care professional for this condition?_____
What have you done for this condition?_____

(Continue on Reverse Side)

Please draw your complaints below:

R **L** **L** **R**



IN THE PAST YEAR I HAVE EXPERIENCED:

- □ Headaches
- □ Neck Pain
- □ Numbness in Hands/Arms
- □ Pain/Numbness in Legs/Feet
- □ Low Back Pain
- □ Shoulder/Hip Pain
- □ Pain Between Shoulders
- □ Cold Hands/Feet
- □ Loss of Smell or Taste
- □ Dizziness
- □ Depression
- □ Drug Side Effects
- □ Lights Bother Eyes
- □ Loss of Balance
- □ Nervousness

□ Stiffness	□ Joint Swelling	□ Fever	□ Fatigue
□ Tension	□ Ringing in Ears	□ Jaw/TMJ Problems	□ Allergies
□ Diarrhea	□ Constipation	□ Upset Stomach	□ Heartburn/Reflux
□ Asthma	□ Chest Pain	□ Heart Attack	□ High Blood Pressure
□ Stroke	□ Cancer	□ Diabetes	□ Painful Urination

ALL PATIENTS: I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature:_____ Date:_____

INSURANCE PATIENTS: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me (patient). Furthermore, I understand that Stevens Creek Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend payment or terminate my care and treatment, any fees for professional services rendered me will immediately be due and payable.

Patient Signature:_____ Date:_____

Thank You!