

Valley Chiropractic-Patient Intake Form

21740 Devonshire Street

Chatsworth, CA 91311

Patient Name _____ Birth Date _____ Sex M / F
Address _____ City _____
State _____ Zip _____ Home Phone (____) _____ Cell Phone (____) _____
Social Security # _____ Driver License # _____ Referred By _____
Email Address _____ @ _____
Occupation _____ Employer _____ Work Phone (____) _____
Work Address _____ City _____ State _____ Zip _____
Spouse Name _____ Primary Care Physician Name _____

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

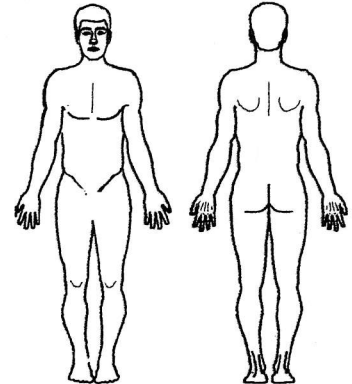
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

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?

(Occasional) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

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

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

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

Please check all of the following that apply to you:

- Recent Fever
- Diabetes
- High Blood Pressure
- Stroke (date) _____
- Corticosteroid Use (cortisone, prednisone, etc.) _____
- Taking Birth Control Pills
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Cancer/Tumor (explain) _____

- Osteoporosis
- Epilepsy/Seizures
- Other Health Problems (explain) _____

- Prostate Problems
- Menstrual Problems
- Urinary Problems
- Currently Pregnant, # weeks _____
- Abnormal Weight Gain Loss
- Marked Morning Pain/Stiffness
- Pain Unrelieved by Position or Rest
- Pain at Night
- Visual Disturbances
- Surgeries _____

Medications _____

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

I certify to the best of my knowledge, 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 provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor 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 _____ Date _____