Total Care Chiropractic
22706 Aspan Street, Ste. 603-B
Lake Forest, CA 92630
949-380-1166

Patient History Form

Date:_____ ID#(office use):_____

Name:_____ Email:_____

Address: _____ City:_____ Zip: _____

Phone (home):_____ Phone (work):_____ Phone (cell):_____

Date of Birth: _____ Sex: __M __F Social Security #:_____

Marital Status: __S __M __D __W # Children & age:_____

Occupation:_____ Employer:_____

Spouse's Name: _____ Spouse's Occupation: _____

Spouse's Occupation: _____ Employer:_____

Referred by: _____

Insurance Information

Insured's Name:_____ Insured's Date of Birth: _____

Insured's Social Security #:_____ Insured's Phone #:_____

Insurance Company Name:_____

Group #:_____ ID#:_____

I understand and agree that regardless of my insurance status, I understand and agree that all services rendered to me and charged are my personal responsibility. I will notify the office of any changes in my status or any changes in the above information as soon as possible. I AMAWARE AND UNDERSTAND THAT IF ANY CHECKS ARE MAILED TO MY HOME, I SHALL PROMPTLY DELIVER THE CHECK TO Total Care Chiropractic. IF CHECKS ARE NOT DELIVERED, I WILL BE RESPONSIBLE FOR ALL CHARGES IN FULL.

Current Condition

How would you describe your chief complaint at this time?_____

_____

_____

When did it start?_____

How would you describe your pain?_____

□ sharp □ dull □ throbbing □ numbness □ aching □ shooting □ burning □ tingling □ cramps □ stiffness

□ Soreness □ swelling □ Other: _____

What makes the pain worse?_____

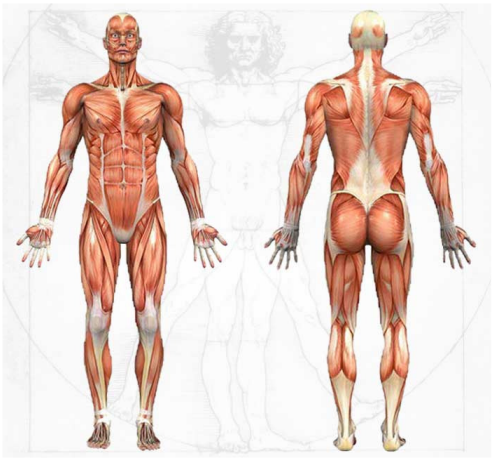
What makes the pain better?_____

Is this condition getting progressively worse?_____

At what time of the day or week is your pain worse?_____

What activities are difficult to perform?_____
□ Sitting □ Standing □ Walking □ Bending □ Lying down □ Other: _____

Please indicate the type and location of your symptoms you are experiencing:
A = Ached B = Burning N = Numbness P = Pins & Needles S = Stabbing



Have you had this problem in the past? □ Yes □ No If yes, how often? _____

What treatment have you already received for your condition?_____
□ Medication □ Surgery □ Physical Therapy □ Other: _____

Is your pain the result of a motor vehicle accident? □ Yes □ No_____

If yes, have you filed a claim? □ Yes □ No_____

Is your pain the result of a work related injury? □ Yes □ No_____

If yes, have you filed a worker's compensation claim? □ Yes □ No_____

Please list accidents, injuries, surgeries and hospitalizations you have had:_____
_____
_____
_____

Medical History

Do you drink coffee? □ Yes □ No If yes, how much per day?_____

Do you smoke tobacco? □ Yes □ No If yes, how much per day?_____

Do you drink alcohol? □ Yes □ No If so, how often?_____

What activities do your daily work habits include?_____
□ Sitting □ Standing □ Light labor □ Heavy labor □ Driving □ Computer work □ Other: _____

What type of exercises do you perform on a daily basis?_____
□ None □ Moderate □ Heavy Type: _____

How many times do you engage in physical activity that is sufficient prolonged and intense to cause sweating and raise your heart rate? □ Never □ 1-2/week □ 3-4/week □ 5-6/week □ everyday

What medications, vitamins, supplements, herbs do you take?_____
_____

Please, list any allergies that you have:_____

Have you ever suffered from:

□ Allergies	□ Dizziness	□ Heart Problems	□ Nose Problems
□ Arthritis	□ Ear Problems	□ High Blood Pressure	□ Stomach or Digestion Problems
□ Cancer	□ Eye Problems	□ Low Back Pain	□ Stroke
□ Chronic Sinus	□ Fatigue	□ Low Blood Pressure	□ Swollen Joints
□ Circulation	□ Foot Trouble	□ Menstrual Problems	□ Tingling or numbness in
□ Constipation	□ Frequent Colds	□ Neck Pain or Stiffness	___Arms___Elbows /Knees___Hands/Feet
□ Breathing Difficulty	□ Headaches	□ Nervousness/Depression	___Hips___Legs___Shoulders

OPERATIONS AND PROCEDURES

Accidents/Falls_____Date_____
Head Injuries_____Date_____
Broken Bones_____Date_____
Dislocations_____Date_____
Other_____Date_____

Does your family have any conditions like diabetes, cancer, high blood pressure, cholesterol ect….

Family Member	Condition
_____	_____
_____	_____
_____	_____

Patient's Signature:_____Date: _____

Guardian's Signature: _____Date: _____