

Please answer every question below so that we can provide you with the best possible service.

## SECTION 1

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_ File #: \_\_\_\_\_

Name: \_\_\_\_\_

What do you prefer to be called?: \_\_\_\_\_

Male \_\_\_\_ Female \_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SSN#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Mailing address: \_\_\_\_\_  
City State Zip

Email address: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Other Phone #: \_\_\_\_\_

Whom may we thank for referring you?: \_\_\_\_\_

Who is your employer?: \_\_\_\_\_

Employer's address: \_\_\_\_\_  
City State Zip

Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed  Domestic Partner

Children:  Yes  No Number of children \_\_\_\_\_

## SECTION 2

*(Please read carefully and initial)*

HMCC/CWC invites you to discuss with us any questions regarding your care and our services. The best health care is based on a friendly, mutual understanding between provider and patient.

HMCC/CWC requests payment in full for all services at the time of visit, unless other arrangements have been made.

\_\_\_\_ I understand that HMCC/CWC can bill my insurance as a courtesy and I am ultimately responsible for payment of services provided.

\_\_\_\_ I hereby authorize HMCC/CWC and whomever they designate to administer treatment as they so deem necessary. I also authorize the provider(s) and / or managed care organization to release my information to provide other health care providers with information related to my care as well as to process insurance claims.

\_\_\_\_ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by  Rex Stevens, D.C.  Molly Stevens, D.C.  Sandy Sachs, D.C.

\_\_\_\_ I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I authorize the treating doctor to provide the necessary treatment that is within the scope and common practice of the chiropractic license in the State of California.

\_\_\_\_ I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment from my present condition(s) and for any future condition(s) for which I seek treatment in this office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We look forward to being YOUR resource for chiropractic care on the central coast

- Drs. Rex and Molly Stevens and Dr. Sandy Sachs

**S E C T I O N 3**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please explain the primary reason for visiting our office:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

When did your current condition begin? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Have you ever had this condition before?  Yes  No If so, please describe: \_\_\_\_\_

Was this the result of an accident?  yes  no

If yes, was it from  auto  work-related  other \_\_\_\_\_

Would you describe the problem as  getting better  getting worse  constant  comes and goes?

Is the problem interfering with your work, sleep, daily routine? If so, please describe: \_\_\_\_\_

Have you sought any other treatment before this?  Yes  No If so, please describe: \_\_\_\_\_

Have you ever been to a chiropractor before?  Yes  No If so, whom? Name: \_\_\_\_\_

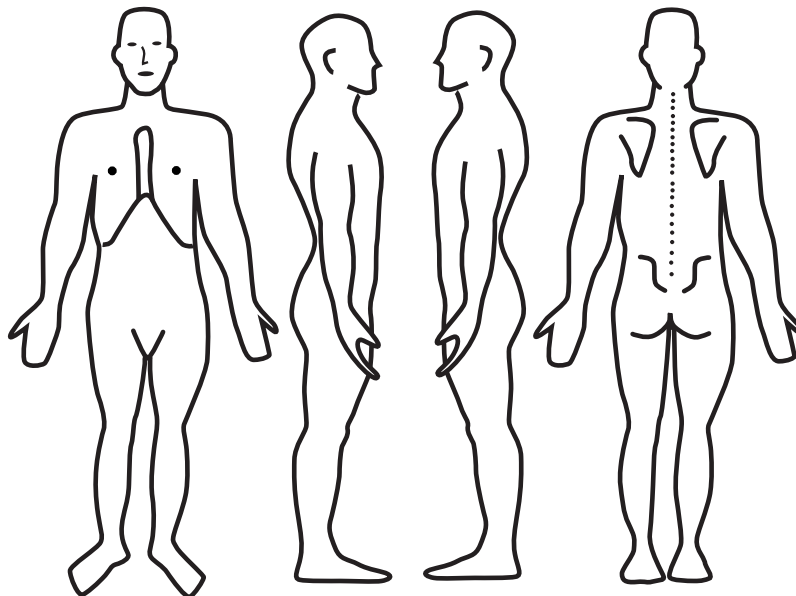
Where? \_\_\_\_\_ What did you enjoy most about their care? \_\_\_\_\_

What other forms of health care do you use?  Acupuncture  Massage \_\_\_\_\_

MD \_\_\_\_\_ name  Other \_\_\_\_\_

**S E C T I O N 4**

Please show me where you are experiencing pain and/or discomfort:



Front

Right

Left

Back

**SECTION 5**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list any supplements you are taking, including vitamins, herbs, etc.?**

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Please list any medications you are taking, including over the counter meds?**

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Have you had any of the following condition(s)?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart attack/stroke     | <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Heart Murmur        |
| <input type="checkbox"/> Congenital Heart defect | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Shingles                | <input type="checkbox"/> Emphysema/ Glaucoma |
| <input type="checkbox"/> Artificial Valves       | <input type="checkbox"/> Arthritis (type) _____  | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Ulcers/Colitis      |
| <input type="checkbox"/> Diabetes/Tuberculosis   | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Eye Disorders       |

Please list any other serious medical conditions you have or ever had:

**Medical Conditions****Surgeries****Serious Accident/Trauma**

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 1. _____ | 1. _____ |
| 2. _____ | 2. _____ | 2. _____ |
| 3. _____ | 3. _____ | 3. _____ |

Please list anything you may be allergic to:

\_\_\_\_\_

**SECTION 6****Health habits:**

What do you do for physical activity? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

I eat **1 2 3 4 5 >5 (circle one)** meals per dayMy diet consists of **(circle all that apply)**: fruits, vegetables, chicken, fish, beef, fast foods, sodas, caffeine

I drink approximately \_\_\_\_\_ cups of water/day

How much un-interrupted sleep do you get per night? \_\_\_\_\_

I sleep on my **(circle all that apply)** back side (R/L) stomachMy pillow is **(circle one)** too hard too soft just right

How old is your mattress? \_\_\_\_\_ Is it comfortable? \_\_\_\_\_

Would you be interested in additional information regarding:

1. Therapeutic Pillows  yes  no  
 2. Vitamin Supplementation  yes  no  
 3. Orthotics/foot supports  yes  no

Do you smoke?  No  Yes/ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Alcohol intake \_\_\_\_\_ per week

**Please check if you experience or have experienced:**

Past Present

- Headaches
- Migraines
- Insomnia
- Dizziness
- Loss of Smell
- Ringing in Ears
- Loss of Balance

- Sinus Trouble
- Recurrent Sore Throat
- Chronic Cough
- Skin Conditions
- Allergies
- Asthma
- Eczema/Rash
- Scalp Disorders

- Poor Memory
- Anxiety
- Rapid Heart Rate
- Depression

Past Present

- Vomiting
- Constipation
- Diarrhea
- Urinary Disorder
- Bed-wetting
- Digestive Disorder

- Pain in Head
- Pain in Jaw/TMJ
- Neck Soreness
- Shoulder Pain
- Shoulder Stiffness
- Shoulder Tension
- Arm Pain
- Tennis Elbow
- Loss of Arm Power
- Pins & Needles in Hands
- Loss of Grip

Past Present

- Mid-back Pain
- Mid-back Tension
- Pain in Ribs
- Low Back Pain

- Low Back Weakness
- Low Back Stiffness
- Hip Pain/Stiffness
- Buttock Pain
- Leg Pain
- Leg Cramps
- Pins & needles in Legs
- Knee Trouble
- Foot Trouble
- Pins & needles in Feet
- Ankle Pain

**For women:** Are you taking birth control?  Yes  No Are you pregnant?  Yes  No  Not sure

Are you nursing?  Yes  No

Are you experiencing menopausal symptoms?  Yes  No  If yes, please describe

Are you experiencing any breast soreness/lumps?  Yes  No