



LEE CHIROPRACTIC OFFICE
 2821 Crow Canyon Road, Suite 104
 San Ramon, CA 94583
 (925) 838-4222

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Driver's Lic. No. _____

Name _____ Social Security _____ Home Phone _____

Address _____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital: M S W D How many children? _____

Occupation _____ Employer _____

Address _____ Office phone _____

E-mail Address _____ Referred by _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Address _____

Is this on a Workmen's Compensation or Auto Insurance Policy claim? _____

Date symptoms appeared or accident happened: _____

Patient ever had same or similar condition: Yes _____ No _____ If yes when and describe _____

Have you lost any days from work? _____

Date of last physical examination: _____ Female: Are you Pregnant? _____

What operations have you had? _____

Serious illness? _____ Fractured bones? _____

Have you ever been under Chiropractic Care? Yes No Doctors Name _____

Have You Ever Significantly Suffered From:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sclatica | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Spinal curvatures | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Sinus infection | <input type="checkbox"/> Kidney Infection or Stone |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Colon trouble | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prostate trouble |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Difficult digestion | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cramps or backache |
| <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Nausea | <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Excessive menstrual flow |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Deafness | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Ear Noise | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Enlarged Thyroid | <input type="checkbox"/> Anemia | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Failing vision | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Tingling or numbness in: | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Difficult breathing | |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pleurisy | |
| <input type="checkbox"/> Arms | | <input type="checkbox"/> Swelling of ankles | |
| <input type="checkbox"/> Elbows | | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Hands | | | |

HABITS:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

DO YOU:
 Now take Vitamins or minerals? Yes _____ No _____

Think you may need vitamins or minerals? Yes _____ No _____

Are you wearing: Heel lifts _____ Sole lifts _____
 Inner soles _____ Arch supports _____

PLEASE PRINT

Purpose of this appointment (Major Complaint) _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes _____ No _____ Constant _____ Comes and goes _____

Is this condition interfering with your: Work _____ Sleep _____ Daily Routine _____ Other _____

What do you believe is wrong with you? _____

Other Doctors seen for this condition _____

Have you been treated for any health conditions by a physician in the last year? Yes _____ No _____

Describe _____

What medications or drugs are you taking? _____

Remarks and additional information: _____

I agree to make a personal payment on my account monthly, regardless of any insurance I may have. (Excepting Worker's Compensation and Personal Injury cases.) **PLEASE INITIAL BOX**

Are you Insured? Yes _____ No _____ Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Lee Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Lee Chiropractic will be credited to my account on 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 or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Information Taken by _____

Onset _____ First Visit _____

Prov. _____

Pall. _____

Qual. _____

Rad. _____

Site _____

Med. _____

Fx. _____

Surg. _____

AA. _____