ACCT#_____
DOCTOR: _____

LEE CHIROPRACTIC

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

PLEASE PRINT CLEARLY

PERSONAL INFORMATION

DATE:

Legal Name_____Nickname_____
Address_____City_____State_____Zip_____
SSN_____ Birth Date_____ Age_____ Sex: M F Marital Status: M S W D
Women: Are you pregnant? __Yes __No If Yes, how many weeks:_____ How many children: _____
Home Phone _____Cell Phone_____ Work Phone _____
Employer_____ Job Title _____
E-mail_____ How did you hear about our office: _____
Name of Spouse _____ Employer/Job Title _____

INSURANCE INFORMATION

Are you insured? __Yes __No Insurance Company Name _____
Would you like us to bill your insurance? __Yes __No
Is this a Workmen's Compensation Claim? __Yes __No If yes, please provide date of accident_____
Is this an Auto Insurance Policy Claim? __Yes __No If yes, please provide the date of accident_____

MEDICAL HISTORY

Have you ever been under chiropractic care? __Yes __No Doctor's Name _____
Date of last physical examination: _____
Date of last X-Ray/MRI/CT Scan: _____
What medications or drugs are you taking? _____
Has your physician treated you for any serious health conditions in the past year? __Yes __No
If yes, provide when and describe _____
Do you exercise? __Yes __No If yes, describe what type and how often _____
Have you: Had any major surgeries? Fractured bones? Been hospitalized? Suffered a sprain/strain? Or been in an auto accident? Please describe.

_____

_____

Have you ever significantly suffered from any of the following?

__Allergies	__Foot trouble	__Diabetes	__Enlarged thyroid
__Dizziness	__Low back pain	__Sciatica	__High blood pressure
__Fatigue	__Neck pain/stiffness	__Spinal curvatures	__Anemia
__Headache	__Frequent urination	__Swollen joints	__Stroke
__Insomnia	__Kidney infection/stone	__Colon trouble	__Chest pain
__Ulcers	__Prostate trouble	__Difficult digestion	__Difficult breathing
__Nervousness	__Cramps/backache	__Nausea	__Swelling of ankles
__Depression	__Poor circulation	__Asthma	__Cancer
__Arthritis	__Rapid heart beat	__Bruise Easily	__Osteoporosis
__Bursitis	__Nosebleeds	__Ear Noise	

Please continue on the back

HISTORY OF CURRENT COMPLAINT

Reason for today's appointment (Major Complaint)_____
Date symptoms appeared_____ Have you lost any days from work or school? __Yes __No How many?_____
How condition began_____
What activities aggravate your condition? _____
What activities seem to help 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 _____
Briefly describe your discomfort (sharp pain, dull pain, numbness, tingling, etc.)
_____
_____

In the past week, how much has your pain interfered with your daily activities (e.g., work, chores, driving)?

O 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on activities

How often are your symptoms present? (Occasional) __ 0-25% __ 26-50% __ 51-75% __ 76-100% (Constant)

What is the severity of your discomfort?

O 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Have you ever had the same or similar condition? __Yes __No
If yes, provide when and describe _____
Have you seen other Doctors for this condition? __Yes __No Date_____ Doctor's Name _____

I certify to the best of my knowledge, the above information is complete and accurate. I understand that I am liable for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient or Guardian Signature _____ Date _____

TO BE COMPLETED BY DOCTOR ONLY
Information taken by: _____
Onset_____ How? _____
Prov._____
Pall. _____
Qual. _____
Rad. _____
Site/Severity _____
_____
Med. _____
Fx. _____
Surg._____
AA. _____
Other Injuries/Notes: _____
_____
_____
_____