ANTHONY CHIROPRACTIC
Wellness & Longevity

PERSONAL INFORMATION:

Name: ____ Date: _____________________________

Address: __________________________________City/State/ Zip: _______________________________________

Home Phone #: (__)____-__________ Work Phone #: (__)____-__________ Cell Phone #: (__)____-_________

Email Address: ______________________________ Male _____ Female: _____ DOB: _____________ Age: ___

Occupation: _____________________Employer Name And Address:_____________________________________

Best Time To Contact: ____________________ Status: S M D W # of children ____________________

Who referred you to this office? _________________________ Have you had previous chiropractic care? ___

CLAIM INFORMATION:

Is your condition due to: an auto accident ( ) a personal injury ( ) a work injury ( ) other ( )

Type of claim: Cash ( ) Group Health Insurance ( ) Personal Injury ( ) Workers' Comp ( ) Medicare ( )

I will be paying today by: cash ( ) check ( ) Visa ( ) MasterCard ( ) other ( ) _________________________

INSURANCE:

Name of Insured: ________________________ Relationship to insured? Self ( ) Spouse ( ) Child ( ) Other ( )

Primary Insurance Co: _________________________________ Identification No.: ______________________

Secondary Insurance Co: _______________________________ Identification No.: ______________________

Please give your insurance card to the receptionist so we can make a copy for your file.

YOUR HEALTH:

Please place an .X. on the scale above marking where you believe your level of health and wellness is at this time. Place a circle (o) on the diagram indicating where you would ***like*** *your health and wellness to be.*

YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the General History page.

Health Concerns:	Rate Severity 1 = mild – 10 = worst	When did this start?	Are symptoms constant or intermittent?	Did problem begin with injury?

Since the problem started, it is… The Same ____ Getting Better ____ Getting Worse ____ **What makes the problem worse?** ____

What, if anything makes it feel better? ____

Does this interfere with your: Work ____ Leisure ____ Sleep ____ Sports ____ Other: ________________

____

Have you seen other doctors for this condition? Chiropractor ___ Medical Dr.____ Other: ______________

Name/ Address: ____

Date: _________________________________ What was the diagnosis? ______________________________

Name/ Address: ____

Date: ________________________________ What was the diagnosis? ______________________________

Have you suffered from any of the following? (Mark with a "P" for past and/or a "C" for current.)

__ Headaches	__ Pins and needles in legs	__ Fainting	__ Neck pain
__ Pins and needles in arms	__ Loss of smell	__ Back Pain	__ Loss of balance
__ Dizziness	__ Ear Noises	__ Sciatica/Leg Pain	__ Nausea
__ Numbness in fingers	__ Numbness in toes	__ Urinary Problem	__ Stomach Problems
__ Fatigue	__ Depression	__ Irritability	__ Tension
__ Sleeping problems	__ Stiff Neck	__ Cold Hands	__ Cold Feet
__ Diarrhea	__ Constipation	__ Fever	__ Hot Flashes
__ Cold Sweats	__ Lights bother eyes	__ Nosebleeds	__ Heartburn
__ Mood Swings	__ Menstrual Pain	__ Menstrual Irregularity	__ Ulcers
__ Nervousness	__ Arthritis	__ Bursitis	__ Foot Trouble
__ Cancer	__ Diabetes	__ Alcoholism	__ Itching
__ Varicose Veins	__ Poor Posture	__ Allergy	__Spinal Curvatures
__ Colon Trouble	__ Hemorrhoids	__ Kidney Infection/Stone(s)	__ Asthma
__ Frequent Urination	__ Anemia	__ Prostate Trouble	__ Bruise Easily
__ Slow Heartbeat	__ High Blood Pressure	__ Low Blood Pressure	__Rapid Heartbeat

General History:

List all medications you are taking and why: (Prescription and non-prescription)

____

Have you had any surgeries or hospitalizations? (Please include all surgeries)

____

____

____

Have you ever had any work related injuries? ________ **When?** ___________________________________

Have you ever had any slips, falls or auto accidents? ____

____

On a scale of 1-10 describe your psychological/emotional stress levels (1= none/ 10=extreme)**:**

Occupational: ____

Personal: ____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits: _______ Exercise habits: ______ Sleep: ______ General Health: ______ Mind-set: ______

FAMILY HISTORY:

Mother (M), Father (F), Brother (B), Sister (S), Aunt (A), Uncle (U), Grandmother (GM), Grandfather (GF), on Mother's side (M), on Father's side (F)

____ Stroke ____ Heart Disease/Attack ____ High Blood Pressure ____ Diabetes ____ Obesity

____ Thyroid Dysfunction ____ Psychological Disorders ____ Alzheimer's Disease

Cancers: ____ breast ____ testicular ____ lung ____ colon ____ liver

YOUR GOALS: At our office we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness in the spaces provided.

Physical Goals:	**Nutritional/ Biochemical Goals**	**Psychological Goals**
________________________	________________________	________________________
________________________	________________________	________________________
________________________	________________________	________________________

Have you ever:

Bought bottled water:	__ Yes	__ No
Belonged to a health club:	__ Yes	__ No
Consumed vitamins or supplements	__ Yes	__ No
If there is a need for dietary changes, would you like to know?	__ Yes	__ No
If there is a need for specific exercises, would you like to know?	__ Yes	__ No
If there is a need for support in the psychological/mind/body/stress dimension of health, would you like assistance?	__ Yes	__ No

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature____ Date: ___________________

Thank you for filling out this form. It is your first step to Creating Wellness!
Return this to our staff and someone will be right with you.

ANTHONY CHIROPRACTIC
Mark Anthony D.C.
3935 Foothill Blvd., La Crescenta, CA 91214
818-957-7035