



California Chiropractic Boshears, Inc.

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Patient Information

Date: _____

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Sex: Male or Female

Age: _____

Date of Birth: _____

Marital Status: Single Married Divorced Widowed

Occupation: _____

Employer: _____

Spouse's Name: _____

Whom may we thank for referring you? _____

Social Security Number: _____

Drivers License# _____

Insurance

Who is responsible for this account? _____

Relationship to patient? _____

Name of Insurance Company? _____ Group # _____

Is Patient covered by additional insurance? Yes or No If yes, please complete below.

Subscriber's Name: _____

Patient's Date of Birth: _____

Relationship to Patient: _____

Insurance Company: _____ Group # _____

Accident Information (If applicable)

Is condition due to an accident? ___ Yes ___ No (If yes, please complete below)

Date of accident: _____ Hour _____ Am/ Pm Where? _____ City _____

Type of accident ___ Auto ___ Work ___ Home ___ Other

To whom have you made a report of your accident?

_____ Auto insurance _____ Employer _____ Worker comp. _____ Other

ACCIDENT INFORMATION (CONTINUED)

Please describe the accident: _____

Have you been treated by another Doctor for this accident? [] Yes [] No

If Yes- Who? _____

If Yes- How long were you treated by this Doctor? _____

Are you: [] Improved [] Unchanged [] Getting worse

ASSIGNMENT AND RELEASE (If applicable)

I, the undersigned certify that I, and or my dependent (s), have insurance coverage with _____ Insurance company and assign directly to Dr. _____ Boshears all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment pain is completed or one year from the date signed below.

Signature of patient, parent, guardian, or personal representative

Please print name of patient, parent, guardian, or personal representative

Date

Relationship to patient

Medications	Reason For Taking It
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

Allergies: _____

Vitamins: _____

In case of emergency contact

Name _____

Relationship _____

Home phone(_____) _____

Work phone(_____) _____

PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is this symptom getting progressively worse? ___ Yes ___ No ___ Unknown

Rate the severity of the pain on a scale from 1 (least pain) to 10 (severe pain) _____

What makes your pain worse? _____ What makes the pain better? _____

Have you ever had a prior episode of this pain? Yes / No If yes, when? _____

Type of pain

___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting
___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ___ Work ___ Sleep ___ Daily routine

Activities or movements that are painful to perform ___ Sitting ___ Standing ___ Walking ___
Bending ___ Lying down

HEALTH HISTORY

What treatment have you already received for your condition?

___ Medications ___ Surgery ___ Physical Therapy ___ Chiropractic services
___ None ___ Other

Name & address' of other doctor (s) who have treated you for your condition _____

Date of last: _____ Physical Exam _____ Spinal X-ray
_____ Blood test _____ Spinal Exam _____ Chest X-ray
_____ Urine test _____ Dental X-ray _____ MRI, Ct –scan, Bone scan

Check YES to indicate if you had any of the following,

And indicate WHEN:

- | | |
|--|---|
| <input type="checkbox"/> Yes AIDS/HIV | <input type="checkbox"/> Yes Liver Disease |
| <input type="checkbox"/> Yes Alcoholism | <input type="checkbox"/> Yes Measles |
| <input type="checkbox"/> Yes Allergy Shots | <input type="checkbox"/> Yes Migraine |
| <input type="checkbox"/> Yes Anemia | <input type="checkbox"/> Yes Headaches |
| <input type="checkbox"/> Yes Anorexia | <input type="checkbox"/> Yes Chicken Pox |
| <input type="checkbox"/> Yes Appendicitis | <input type="checkbox"/> Yes Miscarriage |
| <input type="checkbox"/> Yes Arthritis | <input type="checkbox"/> Yes Mononucleosis |
| <input type="checkbox"/> Yes Asthma | <input type="checkbox"/> Yes Multiple Sclerosis |
| <input type="checkbox"/> Yes Breast Lump | <input type="checkbox"/> Yes Mumps |
| <input type="checkbox"/> Yes Bleeding Disorders | <input type="checkbox"/> Yes Osteoporosis |
| <input type="checkbox"/> Yes Bronchitis | <input type="checkbox"/> Yes Pacemaker |
| <input type="checkbox"/> Yes Bulimia | <input type="checkbox"/> Yes Parkinson's Disease |
| <input type="checkbox"/> Yes Cancer | <input type="checkbox"/> Yes Pinched nerve |
| <input type="checkbox"/> Yes Cataracts | <input type="checkbox"/> Yes Pneumonia |
| <input type="checkbox"/> Yes Chemical Dependency | <input type="checkbox"/> Yes Polio |
| <input type="checkbox"/> Yes Diabetes | <input type="checkbox"/> Yes Prostate Problem |
| <input type="checkbox"/> Yes Emphysema | <input type="checkbox"/> Yes Prosthesis |
| <input type="checkbox"/> Yes Epilepsy | <input type="checkbox"/> Yes Psychiatric Care |
| <input type="checkbox"/> Yes Fractures | <input type="checkbox"/> Yes Rheumatoid Arthritis |
| <input type="checkbox"/> Yes Gout | <input type="checkbox"/> Yes Rheumatic Fever |
| <input type="checkbox"/> Yes Gonorrhea | <input type="checkbox"/> Yes Scarlet Fever |
| <input type="checkbox"/> Yes Glaucoma | <input type="checkbox"/> Yes Stroke |
| <input type="checkbox"/> Yes Goiter | <input type="checkbox"/> Yes Suicide Attempt |
| <input type="checkbox"/> Yes Hernia | <input type="checkbox"/> Yes Thyroid Problems |
| <input type="checkbox"/> Yes Heart Disease | <input type="checkbox"/> Yes Tonsillitis |
| <input type="checkbox"/> Yes Hepatitis | <input type="checkbox"/> Yes Tumors, Growths |
| <input type="checkbox"/> Yes Herniated Disk | <input type="checkbox"/> Yes Typhoid Fever |
| <input type="checkbox"/> Yes Herpes | <input type="checkbox"/> Yes Ulcers |
| <input type="checkbox"/> Yes Kidney Disease | <input type="checkbox"/> Yes Venereal Disease |
| | <input type="checkbox"/> Yes Whooping Cough |
| | Other _____ |

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking/ pk per day _____
 Alcohol
 Coffee/caffeine
 High stress level

Are you pregnant? yes / no (If so, please notify the Doctor today) Due Date _____

Injuries/ Surgeries you've had

Description

Date

<input type="checkbox"/> Falls	_____	_____
<input type="checkbox"/> Head Injuries	_____	_____
<input type="checkbox"/> Broken Bones	_____	_____
<input type="checkbox"/> Dislocations	_____	_____
<input type="checkbox"/> Surgeries	_____	_____

