California Chiropractic Boshears, Inc.

35191 Yucaipa Blvd., Yucaipa Ca. 92399 Phone: (909) 790-5005 Fax : (909) 790-5009

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:

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

==

EXERCISE	**WORK ACTIVITY**	**HABITS**
_____None	_____Sitting	_____Smoking/ pk per day_____
_____Moderate	_____Standing	_____Alcohol
_____Daily	_____Light Labor	_____Coffee/caffeine
_____Heavy	_____ Heavy Labor	_____High stress level

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

Injuries/ Surgeries you've had	**Description**	**Date**
_____Falls	________________________________	______________________
_____Head Injuries	________________________________	______________________
_____Broken Bones	________________________________	______________________
_____Dislocations	________________________________	______________________
_____Surgeries	________________________________	______________________

IMPORTANT: Please check (X) all present symptoms.

HEAD:
[ ] Headache
- [ ] sinus (allergy)
- [ ] entire head
- [ ] back of head
- [ ] forehead
- [ ] temples
- [ ] migraine

[ ] Head feels heavy
[ ] Loss of memory
[ ] Light-headedness
[ ] Fainting
[ ] Light bothers eyes
[ ] Blurred vision
[ ] Double vision
[ ] Loss of vision
[ ] Loss of taste
[ ] Loss of balance
[ ] Dizziness
[ ] Loss of hearing
[ ] Pain in ears
[ ] Ringing in ears
[ ] Buzzing in ears

NECK:
[ ] Pain in neck
[ ] Neck pain with movement
- [ ] Forward
- [ ] Backward
- [ ] Turn to left
- [ ] Turn to right
- [ ] Bend to left
- [ ] Bend to right

[ ] Pinched nerve in neck
[ ] Neck feels out of place
[ ] Muscle spasms in neck
[ ] Grinding sounds in neck
[ ] Popping sounds in neck
[ ] Arthritis in neck

SHOULDERS:
[ ] Pain in shoulder joint (R—L)
[ ] Pain across shoulders
[ ] Bursitis (R—L)
[ ] Arthritis (R—L)
[ ] Can't raise arm
- [ ] above shoulder level
- [ ] over head

[ ] Tension in shoulders
[ ] Pinched nerve in shoulder (R—L)
[ ] Muscle spasms in shoulders

ARMS & HANDS:
[ ] Pain in upper arm
[ ] Pain in elbow
[ ] Movement aggravated
[ ] Tennis elbow
[ ] Pain in forearm
[ ] Pain in hands
[ ] Pain in fingers
[ ] Sensation of pins & needles in arms
[ ] Sensation of pins & needles in fingers
[ ] Numbness in arms (R— L)
[ ] Numbness in fingers (R— L)
[ ] Fingers go to sleep
[ ] Hands cold
[ ] Swollen joints in fingers
[ ] Sore joints in fingers
[ ] Arthritis in fingers
[ ] Loss of grip strength

MID-BACK:
[ ] Mid-back pain
[ ] Location_____________________
[ ] Pain between shoulder blades
[ ] Sharp stabbing
[ ] Dull Ache
[ ] Pain from front to back
[ ] Muscle spasms
[ ] Pain in kidney area

CHEST:
[ ] Chest pain
[ ] Shortness of breath
[ ] Pain around ribs
[ ] Breast pain
[ ] Dimpled or swollen breast
[ ] Irregular heartbeat

ABDOMEN:
[ ] Nervous stomach
[ ] Foods can't eat_________________
[ ] Nausea
[ ] Gas
[ ] Constipation
[ ] Diarrhea
[ ] Hemorrhoids

LOW BACK:
[ ] Low back pain
- [ ] upper lumbar
- [ ] lower lumbar
- [ ] sacroiliac

[ ] Low back pain is worse when:
- [ ] working
- [ ] lifting
- [ ] stooping
- [ ] standing
- [ ] sitting
- [ ] bending
- [ ] coughing
- [ ] lying down (sleeping)
- [ ] walking

[ ] Pain relieves when___________________
[ ] Slipped disk
[ ] Low back feels out of place
[ ] Muscle spasms
[ ] Arthritis

HIPS, LEGS & FEET:
[ ] Pain in buttocks (R—L)
[ ] Pain in hip joint (R—L)
[ ] Pain down leg (R—L)
[ ] Pain down both legs
[ ] Knee pain
- [ ] Inside
- [ ] Outside

[ ] Leg cramps
[ ] Cramps in foot (R—L)
[ ] Pins & needles in legs (R—L)
[ ] Numbness in legs (R—L)
[ ] Numbness in feet (R—L)
[ ] Numbness in toes
[ ] Feet feel cold
[ ] Swollen ankles (R—L)
[ ] Swollen feet

WOMEN ONLY:
[ ] Menstrual pain_________ (where)
[ ] Cramping
[ ] Irregularity
[ ] Cycle_________________ days
[ ] Birth control ___________ type
[ ] Hysterectomy
[ ] Genital cancer
[ ] Discharge
[ ] Color _________________
[ ] Tumors
[ ] Abortions
[ ] Menopause

MEN ONLY :
[ ] Urinary frequency
[ ] Difficulty in starting flow
[ ] Night urination
[ ] Prostate pain/ swelling

GENERAL:
[ ] Nervousness
[ ] Irritable
[ ] Depressed
[ ] Fatigue
[ ] Generally feel run down
[ ] Normal sleep _______________
[ ] Loss of sleep _______________ hrs./night
[ ] Loss of weight ______________ lbs.
[ ] Coffee ____________________ cups/day
[ ] Tea ________________________cups/day
[ ] Cigarettes __________________ packs/day
[ ] Other ______________________
[ ] Diabetes
[ ] Hypoglycemia

HEALTH HISTORY: (DOCTOR'S USE ONLY)

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____