Rhino Chiropractic – 8914.5 Reseda Blvd. Northridge, CA 91324

Patient Data Date ____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ Middle Initial ____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email _____

Date of Birth _____/_____/_____ Sex: Male Female

Social Security Number: _____-_____-_____ Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Complaint Data ____

Major complaint _____

How long have you had this contention? _____ Have you had this condition before_____

When did you last see a chiropractor? _____ Why did you see them?_____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

Did you follow it? _____ If not, why? _____

Why are you changing chiropractors?_____

What is your health philosophy? (What should you do to be healthy?) _____
_____

How did you hear about our office? _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

_____ Temporary Relief (Help the symptom but do not fix the cause of the problem?)

_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

Why did you come to our office and what are your expectations of us?_____
_____

Employer Data_____

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Emergency Contact_____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____			

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Other _____			

Allergies: (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other _____

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Wear Seat Belts:	occasional	always	never

Other _____

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Occupational Activities: (Check one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper

Other _____

Lifestyle Activities:

What are your favorite activities or hobbies to do now?_____

Are your current problems affecting these activities or hobbies?_____

What activities are you looking forward to doing in retirement?_____

Who would you like to be doing these with?_____

On a scale of 1-10 (10 being the most and 1 being the least)

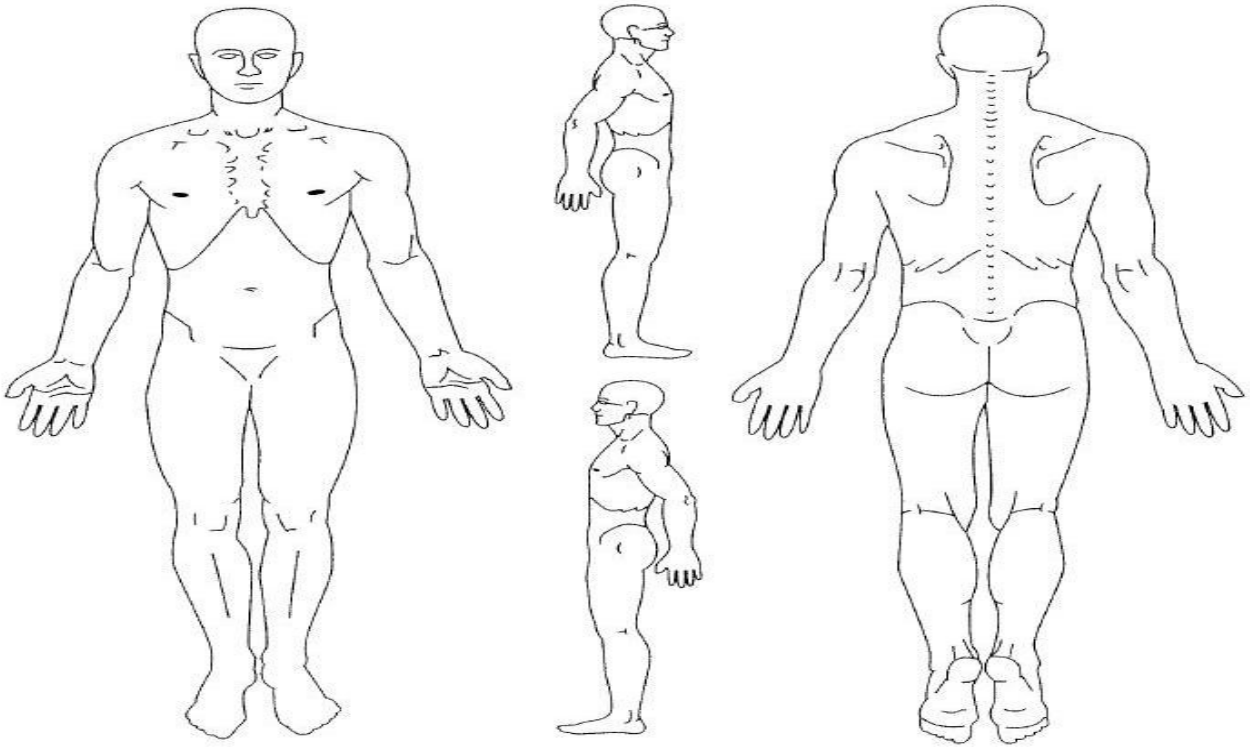
_____ How committed are you to being at your maximum health potential?
_____ How important is it for your family to be at their maximum health potential?
_____ How committed are you to preventing arthritis and maximizing your spinal stability?

Patient Name_____**Date**_____

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? Month_____ **Day**_____**Year** _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How and when did your symptoms begin? _____

_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other _____

Patient Name_____**Date**_____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp Auto Insur. Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: _____am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____

Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Date_____