MODESTO CHIROPRACTIC CENTER-INITIAL HEALTH STATUS

X-Ray: ____________

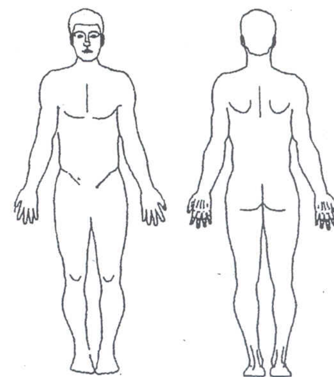
Patient Name: ______________________ Birthdate: __________ Age: ______
Address: ______________________ City: __________ State: ______ Zip: ______
Home Ph: __________ Cell Ph: __________ SSN #: __________ Driver Lic#: __________
Sex: ☐M ☐F Height ______ Weight ______ Marital Status: ______ Kids: ______ Referred By: ______
Occupation: ______________ Employer: ______________ Work Phone: ______________
Spouse Name: ______________ Employer: ______________

DATE INJURY/PROBLEM BEGAN: ______________ Emergency Contact Name & #: ______________

DESCRIBE HOW IT BEGAN:

____
____
____
____

MARK AN X WHERE YOU HAVE PAIN



Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%
Can you perform your daily activities? ☐ Yes ☐ No (Describe) ______________

____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** ______
WHAT AREAS WERE TAKEN? ______________________
Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date) ______________
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births ______
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	History of Low/Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Surgeries/Medications: ______

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment ______________________

Are you Insured? ☐ Yes ☐ No Company ______________________

Insured's name if patient is a dependant ______________ Insured Soc. Sec. No. ______________

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I hereby give my authorization to release any of my medical records which are deemed pertinent and power of attorney to endorse checks made out to me, to be credited to my account.

Patient Signature ______________________ Date ______________

Guardian or Spouse's Signature Authorizing Care ______________________ Date ______________