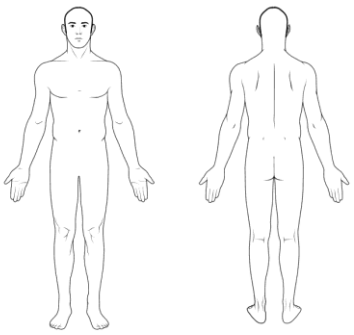
MODESTO CHIROPRACTIC CENTER-INITIAL HEALTH STATUS X-Ray:_____

Patient Name: _____ Birthdate: _____ Age: _____
Mailing Address:_____ City:_____ State:_____ Zip:_____
Primary Ph:_____ Work Ph:_____ SSN#:_____ Driver Lic#: _____
Email Address: _____ Sex: □ M □ F Height:____ Weight :_____
Marital Status: □ Married □ Single □ Divorced □ Widowed #Kids: _____ Referred By:_____
Occupation:_____ Employer: _____ Language Preference: □ English
Spouse Name:_____ Employer:_____ □ Spanish □ Other
Emergency Contact Name & #: _____

CAUSATION:

Date of Injury/condition worsened: _____
□ Auto Accident □ Worsening of prior condition
□ Slip / Fall □ Activity Causing Symptom:
□ Work Injury Explain: _____
_____

Mark an X where you have pain



Current complaint level (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, OR A CT SCAN? □ Yes □ No **Dates/Areas taken:** _____
_____

Family History: □ Arthritis □ Genetic Disorders □ Cancer □ Diabetes □ High Blood Pressure □ Heart issues/Stroke
Please Check the following that apply to you: □ None Apply

Yes	No	Condition	Yes	No	Condition
□	□	History of Recent Infection	□	□	Prostate Problems
□	□	Recent Fever	□	□	Frequent Urination
□	□	HIV/AIDS	□	□	Pregnancies; # of Births _____
□	□	Diabetes	□	□	Abnormal Weight □ Gain □ Loss
□	□	Corticosteroid Use	□	□	Epilepsy/Seizures
□	□	Birth Control Pills	□	□	Visual Disturbances
□	□	High Blood Pressure	□	□	History of Lower/Mid Back Pain
□	□	Stroke (Date) _____	□	□	History of Neck Pain
□	□	Dizziness/Fainting	□	□	Arthritis
□	□	Numbness in Groin/Buttocks	□	□	History of Alcohol Use
□	□	Urinary Retention	□	□	History of Tobacco Use
□	□	Aortic Aneurysm	□	□	History of Depression
□	□	Cancer/Tumor	□	□	Surgeries/Medications: _____
□	□	Osteoporosis			_____
□	□	Recent Trauma			_____

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 dependent_____ Insured SSN #_____

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 heath 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: _____