Urteaga Chiropractic & Sports Medicine

How did you hear about us? ❑ Internet ❑ Insurance ❑ Met Doctor ❑ Referral

Name: _____

General Info

Patient Name:_____Today's Date:_____

Home Address: _____

City:_____ State:_____ Zip Code_____

Home Phone: ( )_____ Cell Phone:( )_____Cell Provider:_____

Email Address:_____

DOB:_____ ID #_____ SSN#: _____

Emergency Contact:_____

Relationship to Patient: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Email:_____

Employment Info

❑ Student ❑ Other:_____

Employer/School:_____

Work Address: _____

City:_____ State:_____ Zip Code_____

Work Phone: _____ Ext: _____ Work Email:_____

Health Insrance Info

Name of Insured:_____

Relationship: ❑ Self ❑ Spouse ❑ Parent ❑ Child ❑ Other:_____

Insurance Provider: _____

❑ PPO ❑ HMO ❑ Medicare ❑ Other: _____

ID #: _____ Policy #: _____ Group #_____

Insurance Phone # (on back of card): _____

Primary Physician: _____ Phone #: _____

Party Responsible for account

❑ Above Patient is Responsible - or - Name:_____

Relationship to Patient: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Email:_____

DOB:_____ ID #_____ SSN#: _____

Medical Information

Age: _____ Height: feet= _____ Inches=_____ Weight: _____lbs

Date of last Mediacl Exam: _____ Doctor's Name: _____

Recent medical procedures:_____ Date:_____

Results:_____

ALL Prescribed Medications:_____

ALL Over-the-Counter Medications:_____

Known congenital (from birth) factors that realte to your condition?

❑ No ❑ Yes➤_____

Previous illnesses/complications from previous injuries?

❑ No ❑ Yes➤_____

Hospitalizations or surgeries? Including childhood?

❑ No ❑ Yes➤_____

Is there any chance you may be pregnant? ❑ No ❑ Yes ➤ # of weeks_____

Check ALL that apply to you:

Yes	No		Yes	No	
❑	❑	Loss of consciousness/ head Injuries	❑	❑	Lupus
❑	❑	Seizues/epilepsy/convulsions	❑	❑	Diabetes
❑	❑	Dizziness/fainting	❑	❑	Pacemaker
❑	❑	Visual disturbances/eye problems	❑	❑	Heria
❑	❑	Nose. Throat, breathing problems	❑	❑	Osteoporosis
❑	❑	Asthma, allergies, allergic reactions	❑	❑	Sleep apnea/sleep conditions
❑	❑	Diarrhea, constipation	❑	❑	Menstrual problems
❑	❑	Numbness In groin/buttocks/legs/feet	❑	❑	Urinary/bladder control problems
❑	❑	Abnormal/rapid weight gain/loss	❑	❑	Recent fever
❑	❑	High blood pressure	❑	❑	Corticosteroid - cortisone, prednisone
❑	❑	Artificial joints	❑	❑	Birth control pills
❑	❑	Night sweats	❑	❑	Pain killers/muscle relaxants
❑	❑	Pain at night	❑	❑	Alcohol/tobacco/drug abuse
❑	❑	Pain unreleived by position/rest	❑	❑	Rheumatoid arthritis
❑	❑	Morning pain/stiffness	❑	❑	Blood disease:_____
❑	❑	Cancer/tumor/lumpos:_____	❑	❑	Stroke - date:_____

Organ problems/diseases: ❑Heart ❑Liver ❑Kidney ❑Stomach ❑Pancreas ❑Gallbladder ❑Lungs ❑Intestines ❑Prostate ❑Uterus ❑Ovaries ❑Thyroid ❑Other:_____

Social Hostory - Check ALL that apply to you:

Daily work/home habits ❑prolonged sitting/standing ❑Heavy lifting ❑Poor posture ❑Other:_____

Eating Habits: ❑Balanced ❑Fast food ❑Vegetarian ❑High fat/carbs ❑Other:_____

Exercise: ❑Walk ❑Jog/run ❑Lift weights ❑Stretch/yoga ❑Other ➤_____

Daily Work Habits

Sports/activities/hobbies:_____

Family Medical History

Family Member	Age	Health Conditions (cancer, heart disease, arthritis, etc…)

Patient Health Information

What is the primary purpose of your visit?
❑Injury Care ❑Temporary relief care ❑Preventative/correction care ❑Wellness care

Did you injure yourself recently? ❑ No ❑ Yes➢ How? ❑ Auto accident ❑ Work ❑ Other:_____
❑ No ❑ Yes➢ _____
When did you injure yourself? Date:_____
Are you currently receiving treatment for this injury? ❑ No ❑ Yes➢ _____

What are your health goals? (Check all that apply)
❑Reduce/eliminate pain ❑Reduce stress/tension ❑Manage weight/diet ❑Manage diet/nutrition
❑Increase strength/flexibility ❑Increase energy ❑Maintain health ❑Other ➢_____

What services are you seeking?
❑Chiropractic ❑Massage Therapy ❑Mechanical traction ❑Physiotherapy
❑Rock tape. ❑Custom fit orthotics ❑Exercise education/prescrption ❑Sports physical

What are your areas of concern? (Check ALL that apply)

❑Headache:____/10	❑R/L Shoulder:____/10	❑R/L Thigh:____/10
❑Jaw Pain:____/10	❑R/L Elbow:____/10	❑R/L Hip:____/10
❑Neck Pain:____/10	❑R/L Wrist:____/10	❑R/L Knee:____/10
❑Upper back pain:____/10	❑R/L Hand:____/10	❑R/L Foot:____/10
❑Mid-back Pain:____/10	❑R/L Uooer Arm:____/10	❑R/L Ankle:____/10
❑Low back pain:____/10	❑R/L Forearm:____/10	❑R/L Upper Leg:____/10
❑Chest:____/10	❑Abdomen:____/10	❑Lower leg:____/10

❑Other:_____

What makes your condition worse?❑Sitting ❑Standing ❑Walking ❑Bending forward ❑Lying down
❑Other:_____

What makes your condition better?❑Ice ❑Heat/warmth ❑Rest ❑Medication➢_____
❑Other:_____

Is your condition becoming progressively worse? ❑No ❑Yes➢ Details:_____
_____

Have you previously received treatment for this condition? ❑No ❑Yes➢ Check all that apply
❑Surgery ❑Medications ❑Injections ❑Chiropractic ❑Phtsical therapy ❑Acupuncture
❑Other treatment:_____

How long have you had this condition? Since (month/day/year):_____
hours_____ # days_____ # weeks_____ # months_____ # years_____

Does your pain travel/radiate to another area of your body?
❑No ❑Yes➢ body region:_____

Has your condition interfered with your: ❑daily activities ❑work ❑house duties ❑sports
❑ Other:_____

Patient Signature: _____ Date:_____