

457 CARMEN DRIVE - CAMARILLO, CA 93010 (805) 389 - 9222

Name	Referred by							
Address	City	StateZip						
Home PhoneAge	Cell Phone	Work Phone						
E-mail								
☐ Single ☐ Married ☐ Other #of Ch	ildren Name of Spous	e (or parent)						
Employer	Occupation							
Address	City	State	Zip					
Have you ever had Chiropractic care befo	ore?Doctor's name	Date	of last visit					
Family physician								
If you are experiencing any pain (neck, mid back, low back, headaches, etc.), health problems, and/ or other complaints, please list in order of severity and indicate how long you've been experiencing pain.								
1	For how lo	ng?						
2								
3								
4	For how lo	ng?						
Has this problem been getting worse or staying the same?								
Have you been involved in an auto accident in the last 12 months?Date of accident: Do you have an attorney representing you for this auto accident?Attorney: How many other passengers were in the car with you? Please list other doctors consulted for these conditions:								
Have you ever had any surgeries or hosp Please list any current or past injuries and	italizations?Please list:_ d illnesses not listed above:							
Please check all medications (OTC and pr ☐ Muscle Relaxers ☐ Insulin ☐ Birth (☐ Others	Control Pills 🗆 Sleeping Pills 🗀 An	ti-Depressants	ain Killers					
Health Insurance CompanyPolicy Holder Name	Polic	cy NumberRelationship:	□ Spouse □ Child					

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition. In other words, we would like to know how much your health condition (pain and/ or symptoms you may be experiencing) is preventing you from what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

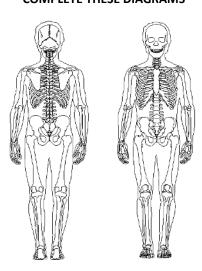
For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF FUNCTIONING. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/ or symptoms you may be experiencing).

<u>0</u>	11	2	3	4	5	6	7	8	9	<u>10</u>	
Complete	ely									Totally	
able to fund	tion								unal	ole to functio	n
1. FAMILY/ HOME RESPO around the house (yard w						•	_			•	
2. RECREATION: Hobbies,	sports, a	nd other	similar l	eisure tin	ne activiti	es.					
3. SOCIAL ACTIVITY: Activing parties, theater,						•	uaintance	s, other	than fam	ily members,	
4. OCCUPATION: Activitie that of a homemaker or v		•	or dire	ctly relate	ed to one	's job, inc	luding no	onpaying	jobs as v	vell (such as	
5. SELF CARE: Activities w getting dressed, etc.).	hich invol	ve persoi	nal mair	tenance	and inde	oendent (daily livin	g (taking	a showe	r, driving,	
6. LIFE SUPPORT ACTIVIT	IES: Basic	life supp	orting b	ehaviors	such as e	ating, sle	eping, an	d breath	ing.		

COMPLETE THESE DIAGRAMS

type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the



This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk
Please initial to indicate you have been made aware if its availability:

i certii	y mai me state	ments made on	uns iorni are co	ompiete and act	urate to the besi	. Of my reconection	л.

Patient's Signature