

Welcome To AV Chiropractic Health Center

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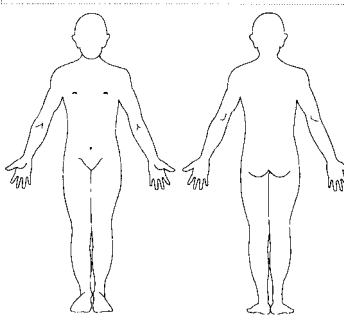
Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient Information	
Patient Name _____	
Today's Date _____	Date of Birth _____
Social Security # _____	
Address _____	
City _____	
State _____	Zip _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Height _____ Weight _____	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Engaged	
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Minor	
How many children do you have? _____	
Please list any family members being treated here _____	
Occupation _____	
Employer/School _____	
Employer/School Address _____	
Employer/School phone #: (_____) _____	

Contact Information	
Home Phone (_____) _____	
Cell Phone (_____) _____	
Email address _____	
May we contact you via (please check for all applicable):	
<input type="checkbox"/> Home phone <input type="checkbox"/> Cell <input type="checkbox"/> Work phone <input type="checkbox"/> Email	
<i>In case of emergency please contact:</i>	
Name _____	
Relationship _____	
Home Phone (_____) _____	
Alternate Phone (_____) _____	
Spouse's/Partner's name _____	
Spouse's/Partner's employer _____	
Who referred you? _____	

Patient Condition			
What is your major complaint (<i>be as specific as possible</i>) _____			
When did you condition/symptoms/pain first appear? (<i>specific date, days ago, weeks, ago, etc.</i>) _____			
Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constant <input type="checkbox"/> Comes and goes			
When is it worse? <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Changes time of day			
Does it interfere with: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily routines <input type="checkbox"/> Recreation <input type="checkbox"/> Other _____			
How long has it been since you really felt good? _____			
Other doctors seen for this condition: <input type="checkbox"/> MD <input type="checkbox"/> DC <input type="checkbox"/> DO <input type="checkbox"/> DDS <input type="checkbox"/> Other _____			
Does the condition/symptom/pain radiate? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, where and how frequently _____			
How long/often does the radiation occur/last? _____			
Do you have: <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness			
Describe _____			
List and mark the severity of your condition/symptoms/pain on the scale below:			
Body part _____	0 (None)	5	(Severe) 10
Body part _____	0 (None)	5	(Severe) 10
Type of Pain:			
<input type="checkbox"/> Sharp	<input type="checkbox"/> Dull	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Tingling
<input type="checkbox"/> Shooting	<input type="checkbox"/> Burning	<input type="checkbox"/> Aching	<input type="checkbox"/> Numbness
<input type="checkbox"/> Other _____			
What activities or positions aggravate your condition?			
<input type="checkbox"/> Bending	<input type="checkbox"/> Coughing	<input type="checkbox"/> Getting up/down	<input type="checkbox"/> Driving
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Standing	<input type="checkbox"/> Staining at stool	<input type="checkbox"/> Turning head
			<input type="checkbox"/> Lifting
			<input type="checkbox"/> Twisting
			<input type="checkbox"/> Lying down
			<input type="checkbox"/> Walking

Mark all areas on the picture where your condition, symptoms, and/or pain occur.



Patient Condition

What activities or positions relieve your condition:

- Heat Lying down Sitting Sitting Stretching Other
 Ice Medication Massage Standing Exercise

Have you ever had this condition before? Yes No If yes, when? _____

Were you treated for this condition or a similar one before? Yes No If yes, when/by whom? _____

Health History

Do you have any allergies? (food, contact, environmental) _____

List any vitamins, herbs and supplements _____

When was your last: Physical examination _____ Blood/lab work _____ X-ray study _____

Injuries/Surgeries you've had and when? _____

Have you had or do you have any of the following conditions or diseases? ***Please check any that apply to indicate yes***

- | | | |
|---|--|---|
| <input type="checkbox"/> AD/HD | <input type="checkbox"/> Connective tissue issues | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Adrenal disorder | <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Knee surgery |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestive/bowel problems | <input type="checkbox"/> Marfan's syndrome |
| <input type="checkbox"/> Autoimmune disorder: _____ | <input type="checkbox"/> Dizziness or vertigo | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Osteoporosis/penia |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Bowel/Bladder problems | <input type="checkbox"/> Food sensitivity | <input type="checkbox"/> Rotator cuff problem |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Fusions (spinal, joint) | <input type="checkbox"/> STI/STD |
| <input type="checkbox"/> Cancer - type? _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Shoulder surgery |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Gall Bladder issue | <input type="checkbox"/> Spinal surgery |
| <input type="checkbox"/> Celiac disease (gluten) | <input type="checkbox"/> Immune compromise | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Hepatitis (A, B, C, etc.) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Herpes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Colitis/diverticulitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Compression fractures | <input type="checkbox"/> Hip replacement | |

Are there any conditions that run in your family? Yes No If yes, what condition(s) and which family member? _____

Personal and Social Health History

Are you currently pregnant, or do you think you may be pregnant? Yes No If yes, how many weeks? _____

How many hours per week do you typically work/attend school? <20 hrs 20 hrs 30 hrs 40 hrs 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc.)? _____

Do you exercise? Yes No If yes, how often and what type? _____

How would you rate your eating habits? Excellent Pretty good Could be better Needs improvement

How well do you sleep? Excellent Pretty good Restless Can't sleep Wake up often

How many hours of sleep do you get daily? _____ hours *and* Do you feel rested in the morning? Yes No

How is your energy overall? Full power OK Low Sporadic/Generally fatigued I depend on caffeine for energy

How often do you get 'sick'? almost never I tend to catch what is going around I'm constantly sick

What do you hope to receive from our program? _____

Thank you for completing our health care questionnaire

AV CHIROPRACTIC HEALTH CENTER

Name: _____

Date: _____

Please take several minutes to answer these questions.

1. How have you taken care of your health in the past?

- a. Medications
- b. Emergency Room
- c. Routine Medical
- d. Exercise
- e. Nutrition/Diet
- f. Holistic Care
- g. Vitamins
- h. Chiropractic
- i. Other (please specify): _____

2. How did the previous method(s) work out for you?

- a. Bad results
- b. Some results
- c. Great results
- d. Nothing changed
- e. Did not get worse
- f. Did not work very long
- g. Still trying
- h. Confused

3. How have others been affected by your health condition?

- a. No one is affected
- b. Haven't noticed any problem
- c. They tell me to do something
- d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

- a. Job
- b. Kids
- c. Future ability
- d. Marriage
- e. Self-esteem
- f. Sleep
- g. Time
- h. Finances
- i. Freedom

5. Are there health conditions you are afraid this might turn into?

- a. Family health problems
- b. Heart disease
- c. Cancer
- d. Diabetes
- e. Arthritis
- f. Fibromyalgia
- g. Depression
- h. Chronic Fatigue
- i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities?

Please give examples: _____

What has that cost you ? (time, money, happiness, freedom, sleep, promotion, etc.)

Give 3 examples:

- 1) _____
- 2) _____
- 3) _____

What are you most concerned with regarding your problem? _____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

Please be specific _____

What would be different/better without this problem? Please be specific _____

What do you desire most to get from working with us? _____

What is that worth to you? _____
