WELCOME TO CALIFORNIA OAKS CHIROPRACTIC

40710 California Oaks Rd. Ste. A, Murrieta CA

698-2511

VITAL INFORMATION

(Thank you for being complete)

Name:_____ Age:____ Date of Birth:_____ Date:_____

Address:_____ City:_____ State:_____ Zip_____

Home Phone:(___)_____ Work Phone:(___)_____ Cell Phone: (___)_____

Social Security#:_____ E-Mail Address: _____

Referred by:_____

Single __ Married__ Divorced__ Widowed__ Name of Spouse: _____

Names and Ages of Children: _____

_____

Your Occupation: _____ Employer:_____

Your Reason or Reasons for seeking Chiropractic care: (be specific) _____

_____

_____

Is this due to an: Auto Accident___ Work Injury___ Other___ Are you Pregnant? Yes___ No___

Have you seen any other doctors for this reason? Yes__ No__ If yes please state who it was and what were your results:_____

Have you ever been to a Chiropractor for any reason? Yes___ No___ Approximate date of last visit_____

Are you under the care of a doctor for any other reason? Yes__ No__ Please explain who and why: _____

_____

Who is your primary Medical Doctor?_____

List any Medications currently taking even if occasional over the counter medications:_____

_____

_____

List any vitamins or supplements you currently take: _____

_____

_____

Do you have trouble falling asleep? Yes __No__ or staying asleep? Yes__ No__

Please rate your Energy level: 0-10 (0 = hard to get going in the morning and 10 = full of Energy all day) ____

(OVER PLEASE)

Please rate your stress level on a scale of 0-10 (0 = no stress and 10 = major stress) in the following areas:

Work____ Home____

Do you exercise regularly? Yes__ No__ Does your complaint interfere with your exercise? Yes__ No __ or prevent you from starting an exercise program? Yes__ No__

How many times a week do you eat away from the house? _____

Do you drink diet drinks with nutrisweet or splenda? Yes ____ No____ How many per week? _____

Do you drink caffeine? Yes____ No____ How much? _____

What do you like to do for enjoyment? _____

_____

Are any of these things affected in any way by your complaint? Yes__ No __

Rate the importance to you of the following on a scale of 0-10 (0= not important 10= very important):

Please be thoughtful!

Better performance (in work and play) ____ Injury Prevention ____ Better health ____ Preventing sickness___

Getting rid of stress_____ Increasing your ability to handle stress____

Are there any other health issues that might affect your family life, work life, or enjoyment of life in any way? Even if they have been there "forever" and you have "gotten used to it" or you chalk it up to "getting older" (like headaches, asthma, acid reflux, morning stiffness). Or is there any other condition you have been told you have?

_____

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed_____ Date_____