

# Welcome to our practice!

## Patient Information

Thank you for choosing Anaya Chiropractic & Sports Injury for your health needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly)

Name: \_\_\_\_\_ Social security number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Sex:  Female  Male Date of birth: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_

Do you prefer to receive appointment reminders via:  E-mail  Home phone  Work phone  Cell phone

Married  Widow(er)  Single  Minor  Separated  Divorced  Partnered for \_\_\_\_ years

Patient employer/school: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer/school address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Spouse or parent's name: \_\_\_\_\_ Employer: \_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

## Responsible Party

Name of person responsible for this account: \_\_\_\_\_ Social security number: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Name of employer: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

## Insurance Information

Insurance company name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of insured person (if other than patient): \_\_\_\_\_

Relationship of insured to patient:  Self  Spouse  Child  Other

Insurance policy number: \_\_\_\_\_ Insurance group number: \_\_\_\_\_

Insurance policy:  Health  Medicare  Automobile  Worker's compensation

Claim number if accident or injury: \_\_\_\_\_ Date of accident or injury: \_\_\_\_\_

Name of insurance case worker (if accident/injury): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Accident/injury is related to:  Employment  Automobile  Other \_\_\_\_\_

## Daily Habits

What type of exercise do you perform on a daily basis?  None  Light  Moderate  Heavy Type: \_\_\_\_\_

What do your daily work habits include? \_\_\_\_\_

What vitamins/nutritional supplements do you currently take? \_\_\_\_\_

Do you smoke?  Never  Former smoker  Occasional smoker  Current smoker How much per day? \_\_\_\_\_

Do you drink alcoholic beverages?  No  Beer  Wine  Liquor How much per week? \_\_\_\_\_

How many caffeinated beverages do you consume daily? \_\_\_\_\_ Type: \_\_\_\_\_

How would you rate your overall health?  Excellent  Very good  Good  Fair  Poor

## Symptoms

Reason for visit: \_\_\_\_\_

When did you first notice your symptoms? \_\_\_\_\_

How do you think your symptoms began? \_\_\_\_\_

Indicate on the drawings to the right where you have pain/symptoms:

How often do you experience your symptoms?

- Constantly (76-100% of the time)  
  Frequently (51-75% of the time)  
 Occasionally (26-50% of the time)  
  Infrequently (1-25% of the time)

How are your symptoms changing with time?

- Getting worse  
  Staying the same  
  Getting better

Type of pain:  
  Sharp  
  Dull  
  Throbbing  
  Numbness  
  Achiness  
  Shooting  
 Burning  
 Tingling  
 Cramps  
 Stiffness  
 Swelling  
 Other: \_\_\_\_\_

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain)    1   2   3   4   5   6   7   8   9   10

What aggravates your condition? \_\_\_\_\_

What makes your condition better? \_\_\_\_\_

What treatment have you received for your condition?

- Medication  
  Surgery  
  Chiropractic  
  Physical therapy  
  Massage  
  None  
  Other \_\_\_\_\_

How much has your condition interfered with your work and social activities?

- Not at all  
  A little bit  
  Moderately  
  Quite a bit  
  Extremely

Do you consider your condition to be severe?  
 Yes  
 Yes, at times  
 No

What concerns you the most about your condition? What does it prevent you from doing? \_\_\_\_\_

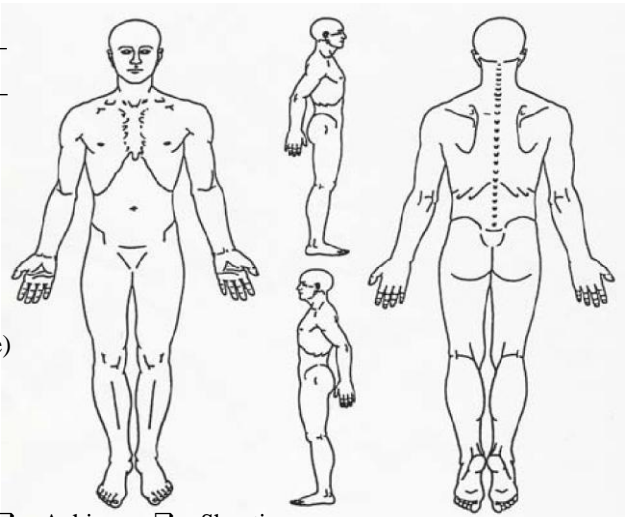
**Health History** Check only those conditions which are applicable: \_\_\_\_\_

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Pinched nerve        |
| <input type="checkbox"/> Neck pain            | <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Gout                | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Upper back pain      | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Mid back pain        | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Prostate problems    |
| <input type="checkbox"/> Low back pain        | <input type="checkbox"/> Blood disorder      | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Psychiatric care     |
| <input type="checkbox"/> Shoulder pain        | <input type="checkbox"/> Breast lump         | <input type="checkbox"/> Herniated disc      | <input type="checkbox"/> Prosthesis           |
| <input type="checkbox"/> Elbow/arm pain       | <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Wrist pain           | <input type="checkbox"/> Bulemia             | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Scarlet fever        |
| <input type="checkbox"/> Hand pain            | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Hip pain             | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Thyroid problem      |
| <input type="checkbox"/> Upper leg pain       | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Measles             | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Knee pain            | <input type="checkbox"/> Chicken pox         | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Ankle/foot pain      | <input type="checkbox"/> Depression          | <input type="checkbox"/> Miscarriage         | <input type="checkbox"/> Tumor/growth         |
| <input type="checkbox"/> Jaw pain             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Typhoid fever        |
| <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Multiple sclerosis  | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> AIDS/HIV             | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Whooping cough       |
| <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Allergy shots        | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pacemaker           | _____   |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Parkinson's disease |   |

(Women) Are you pregnant?  
 Yes  
 No  
 Nursing?  
 Yes  
 No  
 Taking birth control pills?  
 Yes  
 No

List any surgeries/hospitalizations you have had and dates which they occurred: \_\_\_\_\_

List any traumas/motor vehicle accidents/fractures you have had and dates which they occurred: \_\_\_\_\_



**Health History, continued** \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

**Family History** \_\_\_\_\_

Indicate if you have any family members with a history of the following:

- Rheumatoid arthritis    Diabetes    Lupus    ALS    Thyroid condition  
 Heart Problems    Cancer    Stroke    Seizures    Other: \_\_\_\_\_

**Motor Vehicle Accident** (if applicable) \_\_\_\_\_

Date of accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_

How and where did the accident happen? \_\_\_\_\_

Where were you sitting at the time of the accident? \_\_\_\_\_

Please mark the following that apply at the time of the accident:

- Wearing seat belt    Air bag deployed    Body hit interior of car    Ejected from vehicle    Lost consciousness  
 Unaware of impending collision    Aware of impending collision and relaxed    Aware of impending collision and tightened up

What happened after the accident?

- Police arrived    Ambulance arrived    Taken by ambulance to hospital    Police report written  
 Refused treatment    Drove to hospital    Went to doctor's office    Other: \_\_\_\_\_

Immediately after the accident, where did you feel pain/symptoms? \_\_\_\_\_

Currently where do you feel pain/symptoms? \_\_\_\_\_

Other treatment received for this accident: \_\_\_\_\_

**Worker's Compensation Injury** (if applicable) \_\_\_\_\_

Date of injury: \_\_\_\_\_ Time of injury: \_\_\_\_\_

How and where did the injury happen? \_\_\_\_\_

What happened after the injury?

- Continued working    Stopped working    Notified supervisor    Incident report written  
 Drove to hospital    Went to doctor's office    Received no treatment    Other: \_\_\_\_\_

Immediately after the injury, where did you feel pain/symptoms? \_\_\_\_\_

Currently where do you feel pain/symptoms? \_\_\_\_\_

Are you currently working?    Yes, without restrictions    Yes, with restrictions    No

Other treatment received for this injury: \_\_\_\_\_

**Patient Payment Agreement** \_\_\_\_\_

Our policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made with the doctor. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes to my health record.

Signature \_\_\_\_\_ Date \_\_\_\_\_

