

BELL PLAZA CHIROPRACTIC

1052 E. EL CAMINO REAL, SUNNYVALE, CA 94087
(408) 248-7960

PATIENT HISTORY

Today's Date: _____ Date of Injury: _____

Name _____ Home # _____ Work # _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Sex (circle) M / F

Marital Status (circle) Single / Married / Divorced / Widowed

Spouse's Name _____ Number of Children _____ Ages _____

Driver's License Number _____ Social Security # _____

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Primary Insurance _____ Name of Insured _____

Secondary Insurance _____ Name of Insured _____

Is this a: Workers Comp / Auto Accident _____ Referred By _____

List all surgeries _____

List all medications are you currently taking? _____

List all x-rays you've had taken in the last 5 years? _____

(Women only) - Is there any possibility you are pregnant? _____

Have you had previous chiropractic care? No / Yes

Name (if applicable) _____ Date of Last Visit _____

I hereby authorize treatment for Chiropractic care and understand and agree that I am responsible for the full amount of any fees charged for services rendered.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____

Primary Symptom

Describe symptom_____

Date symptom began_____

What increases pain?_____

What decreases pain?_____

Circle symptom: dull ache / sharp / burning / throbbing / tingling / other_____

When at its worst, describe pain on a scale of 0 - 10 (0=no pain; 10=severe pain)_____

Does pain radiate?_____

Where is pain located (i.e., left, right, middle)?_____

Is pain constant, or off & on?_____

Secondary Symptom

Describe symptom_____

Date symptom began_____

What increases pain?_____

What decreases pain?_____

Circle symptom: dull ache / sharp / burning / throbbing / tingling / other_____

When at its worst, describe pain on a scale of 0 - 10 (0=no pain; 10=severe pain)_____

Does pain radiate?_____

Where is pain located (i.e., left, right, middle)?_____

Is pain constant, or off & on?_____

Other Symptom

Describe symptom_____

Date symptom began_____

What increases pain?_____

What decreases pain?_____

Circle symptom: dull ache / sharp / burning / throbbing / tingling / other_____

When at its worst, describe pain on a scale of 0 - 10 (0=no pain; 10=severe pain)_____

Does pain radiate?_____

Where is pain located (i.e., left, right, middle)?_____

Is pain constant, or off & on?_____