ABOUT THE PATIENT

RESILIENCE CHIROPRACTIC | 1040 Davis St. Ste 201, San Leandro, CA 94577

Name | Today's Date | Birthday | Age

Address | City | State | Zip

Home Phone | Cell Phone | Work Phone | Gender ◯ M ◯ F

Significant Other's Name | Kid's Names and Ages

Your Employer | Type of Work

E-Mail Address | Have you been to a chiropractor before? ◯ Yes ◯ No

Emergency Contact | Phone number

Name of Medical Doctor(s)

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Resilience Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins

Enter your full name here

Patient / Parent Signature **(This represents a long term authorization for all occasions of service)**

Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. **How long has this been an issue?**

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/ Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to

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4. **How long has this been an issue?**

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☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to

5. **Does your condition affect:** ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving

6. **What makes it better?**

7. **What makes it worse?**

8. **What Doctor's have you seen for this?**

9. **Type of treatment:**

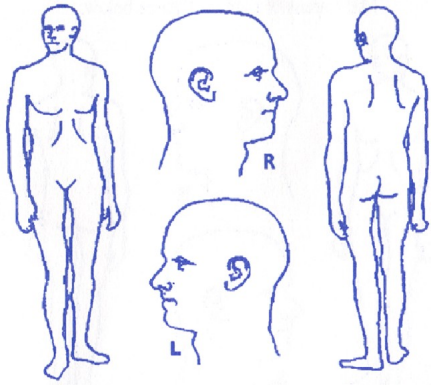
10. **Results**

NOTES:

Are you pregnant?

◯ Yes ◯ No

Mak areas of concern (during appointment)



GENERAL HEALTH HISTORY

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Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
☐	☒	Headache	☐	☐	Urinary Problems
☐	☒	Migraines	☐	☐	Easy Bruising
☐	☐	Shortness of Breath	☐	☐	Tobacco Use
☐	☐	Allergies/Asthma	☐	☐	Dental Problems
☐	☐	Medication Side Effects	☐	☐	Fibromyalgia
☐	☐	Diabetes	☐	☐	Blood Thinner Use
☐	☐	Hands or Feet cold	☐	☐	HIV Positive
☐	☐	Muscle aches	☐	☐	Cancer
☐	☐	Trouble Walking	☐	☐	Depression
☐	☐	Leg / Foot Numbness	☐	☐	Alcohol Use
☐	☐	Fainting	☐	☐	High or ☐ Low Blood Pressure
☐	☐	Gall Bladder Trouble	☐	☐	Stroke History
☐	☐	Ringing in Ears	☐	☐	High Cholesterol
☐	☐	Ear Problems	☐	☐	TMJ
☐	☐	Sleeping Problems	☐	☐	Digestive Problems
☐	☐	Vision Problems	☐	☐	Pain All Over
☐	☐	Thyroid Problems	☐	☐	Tension / Irritability
☐	☐	Liver Disease	☐	☐	Chest Pains
☐	☐	Kidney Problems	☐	☐	Heart Pacemaker
☐	☐	Light Bothers Eyes	☐	☐	Heart Problems
☐	☐	Other			

1. List any medications you are taking:

2. Please list all Doctors you are currently seeing:

3. Has any Doctor or other professional advised you to "Go to a Chiropractor": ◯ No ◯ Yes, Name

PAST HISTORY

4. List any past auto collisions: **Was any care received?**

5. List any past work injuries: **Was any care received?**

6. List any past sport, recreational, or home injuries:

7. List any past hospitalizations and surgeries:

FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication Use ☐ Arthitis ☐ Other

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication Use ☐ Arthitis ☐ Other

Is there any other family history you want us to know?