Crusade Specific Chiropractic ~ 903 30th St. Sacramento, CA. 95816 ~ 916-442-7474

Personal Information: Name_____Address_____

City_____ State_____ Zip_____ Home Phone#_____

Cell# (for confirming appointment schedule)_____Carrier: ___Verizon ___AT&T ___T-Mobile ___Sprint

Preferred Email Address (for confirming appointment schedule) _____

Date of Birth_____ Social Security#_____ Driver's License#_____

Age_____ Height_____ Weight_____Gender_____ Status: Married____ Single____ Widowed____ Divorced____

Emergency Contact_____ Relationship_____ Phone#_____

Person responsible for this account_____ Relationship_____

Occupation_____ Referred by_____

Health Information: Have you ever had Chiropractic care before?_____ If yes, date of last visit?_____
If you are experiencing any pain (neck pain, mid back, low back, etc.), health problems, symptoms, and/or complaints, please list in order of severity.

1._____ For how long?_____

2._____ For how long?_____

3._____ For how long?_____

4._____ For how long?_____

Has this problem been getting _____worse _____staying the same? **Currently or in the past have you experienced any of these complaints while working?** Y____ N____ If yes, please explain:_____
Are there other activities, incidents, or events outside of work that may have caused these complaints? Y____ N____
If yes, please explain:_____

Any other medical conditions? Y____ N____ **If yes, please explain**_____
How would you rate your general health? ____Poor ____Good ____ Excellent
Are you currently seeking health care with another physician? Y____ N____ **If yes, physician name**_____
Contact#_____ **Have you recently had any x-rays or other tests?** Y____ N____ **Results**_____
Number of Children _____**List any past surgeries**_____

Please check all medications (over the counter and/or prescribed) you are currently taking: ___Apsrin/Tylenol ___Pain Killers ___Insulin ___Muscle Relaxers ___Birth Control ___ Sleeping Pills ___ Anti-Depressants ___Steroid medications (Prednisone, Cortisone) ___Anticoagulant medications ___Other (please list)_____
Do you: Smoke Y____ N____ How much_____ Exercise regularly Y____ N____ How often_____ Type of Exercise_____
Do you have any of the following? (check all that apply) ___Dizziness ___Headaches ___Ears Ringing ___Blackouts ___Diabetes ___High Blood Pressure ___Heart Disease ___Respiratory Issues

Insurance Information: Do you currently have medical insurance? Y____ N____ If yes, provider name?_____
For patients over 65, are you covered by Medicare? Y____ N____ Medicare ID#_____
Is your condition due to an accident? Y____ N____ Have you been in an auto accident in the last 12 months? Y____ N____
Were you involved in an auto accident recently? Y____ N____ If yes, what was the date of the accident?_____
Is your condition due to an accident at work? Y____ N____ If yes, what was the date of the accident?_____

Patient Self Assessment: The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

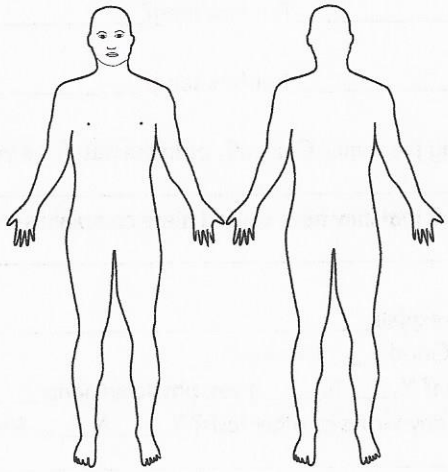
For each of the six categories of daily living listed, **PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** 0 meaning ***no disability*** at all, and 10 meaning that you ***cannot perform*** those activities at all.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

Family/Home Responsibilities: activities related to the home or family
Including chores and duties performed around the house (yard work, household chores,
Errands, favors for other family members, driving children to school, etc.) _____
Recreation: hobbies, sports, and other similar leisure time activities. _____
Social Activity: activities which involve participation with friends and acquaintances other
than family members including parties, theatre, concerts, dining out, other social functions. _____
Occupation: activities that are a part of or directly related to one's job, including
non- paying jobs, such as that of a homemaker or volunteer work. _____
Self Care: activities which involve personal maintenance and dependant daily living
(taking a shower, driving, getting dressed, etc.) _____
Life Support Activity: basic life supporting behaviors such as eating, sleeping,
and breathing. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example: dull, sharp, constant, off & on, when standing, sitting, walking, etc.



Have you had these symptoms, or anything similar in the past? Y____ N____ **If yes, explain**_____
Are you currently seeking treatment for this condition/symptoms with another physician? Y____ N____ **If yes, how long?**_____
If yes, what is the physician name_____ **Contact Info**_____
Doctor's diagnosis?_____ **Treatment medications?**_____
Results?_____ **Length of time/care?**_____

I fully understand that it is a requirement to receive a full examination and x-rays before receiving any care in this clinic. I clearly understand and agree that all services rendered to me on my first visit are charged directly to me and that I am personally responsible for payment on the day services are rendered.

_____ _____

Patient/Guardian Signature **Date**