

Crusade Specific Chiropractic - 1120 Corporate Way, Sacramento, CA 95831 - (916) 442-7474

Personal Information: Date: _____ Name _____ Date of Birth ____/____/____

Cell# (for confirming appointment schedule) _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Preferred Email Address (for confirming appointment schedule) _____

Age _____ Height _____ Weight _____ Sex _____ 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: __Aspirin/Tylenol __Pain Killers __Insulin
__Muscle Relaxers __Birth Control __ Sleeping Pills __ Antidepressants __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 ____

Have you been involved in an auto accident in the last 24 months? 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? _____