ABOUT THE PATIENT

OPTMZ STATE Spine, Movement and Wellness Center, 35 E. 10th St. Suite B, Tracy, CA , 95376

Name _____ Today's Date_____ Birthdate _____ 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? □ No □ Yes

Emergency Contact _____ ph # _____

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 Clinic Name 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.

_____ _____

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_____

2. _____ 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_____

3. _____ 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_____

4. _____ 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_____

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: _____

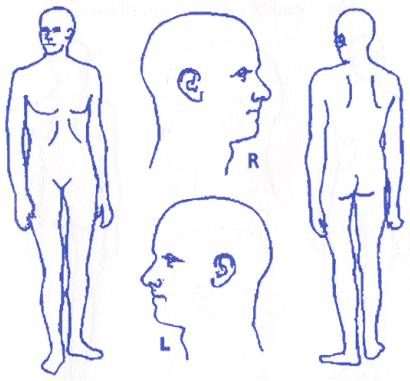
_____

_____

Are you pregnant?

☐ Yes ☐ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

OPTMZ STATE Spine, Movement and Wellness Center, 35 E. 10th St. Suite B, Tracy, CA , 95376)

Patient Name_____ Mark the conditions that apply to you.

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	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. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

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