Pacific Coast
KINESIOLOGY CENTER
Chiropractic . Health . Wellness
Abella-Desuyo Chiropractic Inc.

Personal Information

Name _____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ **Driver's License Number** _____

E-mail: _____

Date of Birth _____ **Sex:** M / F **Marital Status:** S / M / D / W

Emergency Contact (Name, Relation and Phone Number):

_____

Occupation / Employer _____ **Phone** (Work) _____

Present condition due to an injury? ___ Yes ___ No ___ On the Job ___ Auto Accident ___ Other _____

Has the accident been reported? ___ Yes ___ No ___ To Employer ___ Auto Carrier ___ Other _____

Insurance Information

Insurance Carrier/Company_____

ID / Membership / Policy # _____

Are you the primary insured? ____ Yes ____ No

If no, name of insured: _____ Date of Birth of insured: _____

Relationship to insured: _____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Abella-Desuyo Chiropractic Inc / Pacific Coast Kinesiology Center all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co-pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ Private Pay/Cash: By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.
Name of person responsible for this account: _____

_____ _____

Patient Signature (Parent, Legal Guardian or Custodian if minor) Date

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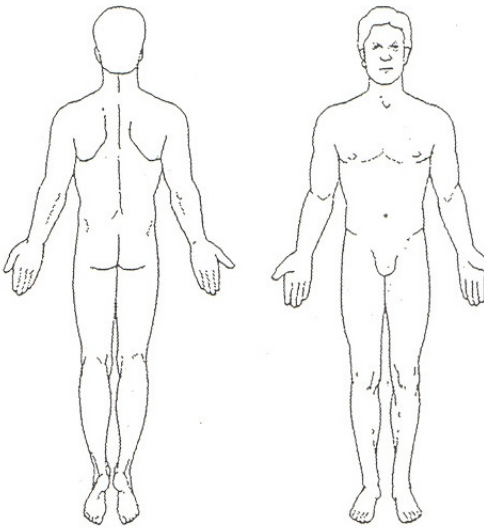
HEALTH REPORT

Reason for seeking care: _____

When did this begin? _____/_____/_____

What is the state of the current condition since the initial onset? _____ Same _____ Better _____ Worse

What area(s) does this pain radiate, shoot or travel to (if applicable)? _____



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain					*Moderate Pain*					*Worst Possible Pain*
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

What aggravates/worsens the area(s) of complaint? _____

What alleviates/relieves the area(s) complaint? _____

How often do you experience your symptoms?

□ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

Is this condition interfering with your (circle all that apply)?:

Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:_____

Is your complaint interfering with your daily activities (check the appropriate box)?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Have you seen other doctors for this complaint? ____ Yes ____ No ; If "Yes", please explain:

_____

Have you received chiropractic treatment previously? ____ Yes ____ No

If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? ____ Yes ____ No

If yes, explain: _____

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Check ALL of the health conditions below that apply to you currently or in the past:

□ Osteoarthritis (OA)
□ Rheumatoid Arthritis (RA)
□ Degenerative Joint Disease
□ Whiplash Injury
Date of injury: _____
□ Cancer
Type: _____
□ Asthma
□ Headaches / Migraines
□ Diabetes
___Type I ___Type II
□ Joint Pain (circle location of pain): Shoulder / Elbow / Hip / Knee / Ankle
Other:_____
□ Heart Problems / Stroke
□ High Blood Pressure / Hypertension
□ Fibromyalgia / Chronic Fatigue
□ Disc Herniation
□ Osteoporosis /Osteopenia
□ Epilepsy / Seizures
□ Genetic Disorders
□ Depression/ Anxiety
□ Anemia
□ Please list any other medical conditions: _____

Are you currently taking medication (prescription and/or over-the-counter)? ____ Yes ____ No
Please list medications:

_____

_____

Are you currently taking any vitamins and/or supplements? ____ Yes ____ No
Please list:

_____

_____

List conditions you are taking medications for: _____

_____

List any history of FRACTURES, INJURIES (broken bones, sprains, strains, major trauma): _____

_____

List the approximate dates of any SURGERIES/HOSPITALIZATIONS or treated conditions: _____

_____

Have you had any diagnostic imaging (Xray, CT, MRI, Ultrasound, etc.)? _____

_____

WOMEN ONLY

Are you currently pregnant? ____ Yes ____ No

Pain/Abnormal menstrual cycle? ____ Yes ____ No

Menopause? ____ Yes ____ No History of childbirth? ____ Yes ____ No

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Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
____ Convulsions
____ Dizziness
____ Fainting
____ Headache
____ Nervousness
____ Numbness
____ Wheezing

MUSCLES & JOINTS
____ Low Back Problems
____ Pain between Shoulders
____ Neck Problems
____ Arm Problems
____ Leg Problems
____ Swollen Joints
____ Painful Joints
____ Stiff Joints
____ Broken Bones
____ Sore Muscles
____ Weak Muscles
____ Walking Problems
____ Sprains/Strains

CARDIO-VASCULAR
____ High Blood Pressure
____ Heart Attack
____ Pain over Heart
____ Poor Circulation
____ Heart Trouble
____ Rapid Heart
____ Slow Heart
____ Strokes
____ Swelling Ankles
____ Varicose Veins

EAR/NOSE/THROAT
____ Earache
____ Ear Noises
____ Enlarged Thyroid
____ Frequent Colds
____ Hay Fever
____ Nasal Blockage
____ Nose Bleeds
____ Pain Behind Eyes
____ Poor Vision
____ Sinusitis
____ Sore Throats

RESPIRATORY
____ Asthma
____ Chronic Cough
____ Spitting Phlegm
____ Spitting Blood
____ Shortness of breath

GENITO-URINARY
____ Blood in Urine
____ Frequent Urination
____ Loss of Bladder Control
____ Kidney Infection
____ Painful Urination
____ Prostate Problems

SKIN OR ALLERGIES
____ Allergy _____
____ Boils
____ Bruising Easily
____ Dryness
____ Eczema/Rash/Dermatitis
____ Hives
____ Itching
____ Sensitive Skin

GASTRO-INTESTINAL
____ Belching/Gas
____ Colon Problems
____ Constipation
____ Diarrhea
____ Excessive Hunger
____ Excessive Thirst
____ Gall Bladder pain
____ Hemorrhoids
____ Liver/Gallbladder
____ Nausea
____ Abdominal Pain
____ Ulcer
____ Weight Loss/Gain
____ Poor Appetite
____ Poor Digestion
____ Vomiting
____ Vomiting Blood
____ Bloody Stool
____ Black Stool

Social

Height: _____ ft _____ in **Weight:** _____ lb

Do you exercise? ____ Yes ____ No **Times per week?** _____

Intensity of exercise/activity? ☐ Light ☐ Moderate ☐ Strenuous Type

Do you currently smoke? ____ Yes ____ Never been a smoker ____ Former smoker

If "yes", how often do you smoke? _____ Current daily _____ Current sometimes

If "yes", what would you say your level of interest is in quitting smoking?

(0 = None, 10 = Very interested; Circle below)

0 1 2 3 4 5 6 7 8 9 10

Do you consume alcohol? ____ Yes ____ No ; ____ Daily ____ Weekly ____ Social Occasions

Do you consume caffeinated drinks? ____ Yes ____ No ; Cups per day ____

Please describe your overall health right now (check the appropriate box):

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What is your current stress level? (check the appropriate box): ☐ Mild ☐ Moderate ☐ High

What are your hobbies? _____

_____

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Family History

Family History (please mark those that apply):

□ Cancer	□ Tumors	□ Stroke	□ Seizures	□ Diabetes
□ High Blood Pressure	□ Heart Disease	□Arthritis	□Genetic Disorders	□ Anemia

□ Other: _____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

_____
Patient Name (Printed)

_____ _____
Patient Signature (Parent, Legal Guardian or Custodian if minor) Date

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the furnishing of my personal medical information to Pacific Coast Kinesiology Center (Dr. Jeanna Abella-Desuyo, D.C.). I authorize Pacific Coast Kinesiology Center to review my medical history as it pertains to my condition while I am undergoing treatment/observation/care, including history obtained, lab work, examination findings, diagnosis, and prognosis.

This authorization also serves to allow Pacific Coast Kinesiology center to release all information regarding my condition while under Dr. Abella-Desuyo's care and treatment protocols to any third parties who may require my records (e.g., insurance companies, law firms, disability agencies, spouse, etc.).

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian if patient is a minor Date

_____ _____
Witness Signature Date