Patient History Form

Dr. D. Joe Tobias, D.C.

Name_____ Address_____

City_____ State_____ Zip_____ Home Ph _____Cell Ph_____

E-Mail Home:_____ E-Mail Work:_____

SSN#_____ Date of Birth_____ Age_____ Height_____ Weight_____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced # of children _____ Name of Spouse_____

How were you referred to our office?_____

Employer_____ Address_____

City_____ State_____ Zip_____ Wk Ph_____ Occupation_____

Have you ever had chiropractic care before?_____ If yes, when?_____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc)

1._____ For how long?_____

2._____ For how long?_____

3._____ For how long?_____

4._____ For how long?_____

List other doctors consulted for these conditions: 1. _____ 2. _____

Name of family physician_____

Do you ever experience any of these complaints while working?_____ If yes, describe activities at work that may be causing you to experience these complaints:_____

Are there any other activities, incidents, or events outside of work that may have caused these complaints?_____ If yes, please explain:_____

_____

If this is due to an injury or auto accident, what is the date of injury or accident?_____

Has this problem been getting better, worse, or staying the same?_____

What activities make your condition worse?_____

Any surgeries or hospitalizations?_____ If yes, please list:_____

Injuries or illnesses that you have had that are not listed above:_____

Please indicate medications (over the counter) / prescriptions you are currently taking: ☐ Aspirin/Tylenol ☐ Pain Killers

☐ Muscle Relaxers ☐ Insulin ☐Tranquilizers ☐ Birth Control Pills ☐ Others_____

Have you been involved in an auto accident in the last 12 months?_____ If yes, when?_____

Health Insurance_____ Policy Holder_____

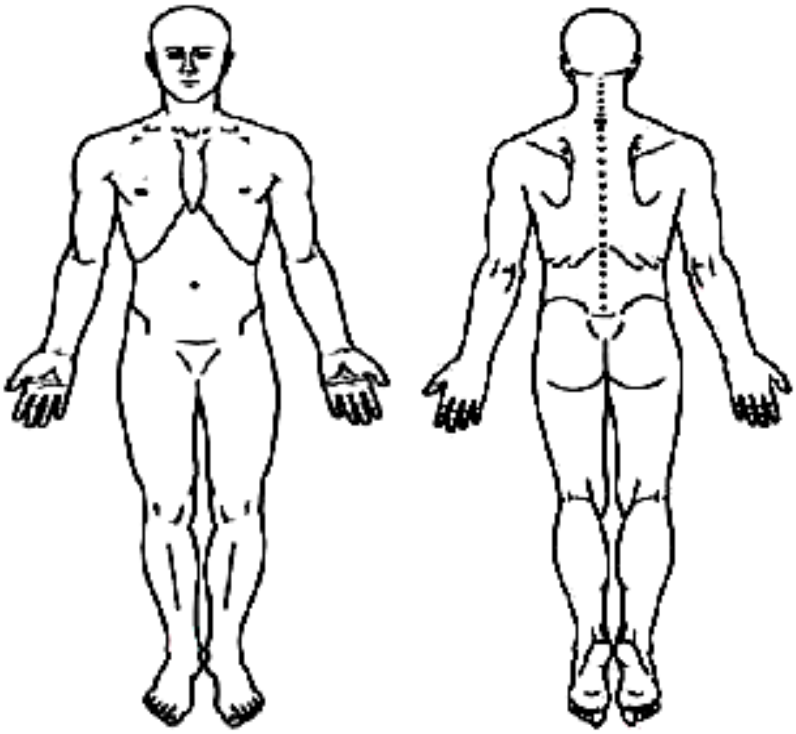
Claims Address_____ Policy Number_____

Spouse's Health Insurance_____ Policy Holder_____

Claims Address_____Policy Number_____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, *dull, sharp, constant, off and on, when standing, when sitting, etc., etc.*

COMPLETE THESE DIAGRAMS



Method of payment you plan to use for today's charges: ☐ Check ☐ Cash ☐ Credit Card

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE OR VERIFY A DIAGNOSIS, TYPE OF TREATMENT AND LENGTH OF TREATMENT. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. **All first visit charges are payable when services are rendered.**
2. **The fee paid for x-rays is for analysis only. California state law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.**

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.

Our office uses sign in sheets, travel cards, and provides care in an open door adjusting environment. Adjustments are done in an open adjusting area. As a result patients are in sight of each other, and some ongoing / routine details of care may be in ear shot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations, or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open door adjusting environment, other arrangements will be made for you. Your signature below authorizes us to contact you at all phone numbers / addresses you list on this intake form. If you do not wish to be contacted at any listed numbers / addresses, please let us know.

Patient's Signature_____ **Date**_____

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