RIVERSIDE
CHIROPRACTIC CENTER
A Healthy Touch from Pediatrics to Geriatrics

Welcome to our office! Please take a few minutes to fill out your information as accurately as you can, so we can fully understand your condition. Please feel free to ask our office staff if you need assistance. Thank you.

Legal Name:____

Date:____________________

Name you would like us to use:____________________________

Phone #:____________________

Gender: Male/Female Age:__________

Date of Birth:____________________ SSN _____________-_________-_____________

Email address: ____

Approximate Height: _______________

Approximate Weight: _______________

Race (circle only 1)
- Asian
- Black or African American
- White
- Declined to State

Ethnicity (circle only 1)
- Hispanic or Latino
- Not Hispanic or Latino
- Declined to State

<u>Current Condition</u>

Do you have a complaint? Describe:____

When did this start? ____

Is this a result of:_____work injury _____auto accident ____personal injury ____other

Have you ever had similar symptoms? Yes_____ No____ When?_________________________________

Does anything make symptoms better? ____

Does anything make your symptoms worse? ____

Choose the best descriptions for your problem: (Check mark all that apply)

__steady/constant	__comes & goes	__throbbing	__aching	__pulling/tight band
__sharp/stabbing	__shooting	__electrical	__boring	__fatigue/weak
__vise-like	__heavy pressure	__itching	__crawling	__colic
__numbness	__tingling	__stiffness		

Please rate the intensity of your symptoms (circle)

At time of onset: *No pain/problems* 0 1 2 3 4 5 6 7 8 9 10 *Worst pain possible*

Today: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the day are you in pain? 0 10 20 30 40 50 60 70 80 90 100%

What percentage do you rest due to pain? 0 10 20 30 40 50 60 70 80 90 100%

How has the problem affected your personality?

___normal, no effect, alert, cheerful
___slightly upset, irritable, complaining
___moderately upset, unhappy, anxious
___severely upset, depressed, bitter
___totally incapacitated, avoid everyone

Has your condition affected your employment, home life, social life or physical activities?
Explain.________________________
____
____

What other doctors have you seen for this condition?
Date of that visit?_____________Their diagnosis?_____________________________________
Results of treatment: Good Fair Poor
Have you tried any self-treatment? If so, please explain.______________________________

Previous treatments and tests for any condition at any time
Please check all that apply

- Acupuncture
- Cervical Collar
- Chemotherapy
- Chiropractic Adjustments
- CT Scan
- Echocardiogram
- Heel lift
- Joint Mobilization
- Massage Therapy
- MRI
- Muscle Stimulation
- Neuromuscular Re-education (muscle work done by Dr. Velos or Dr. Gibbs)
- Physical Therapy
- Traction
- Ultrasound
- X-rays

Please check the box for each symptom you have currently or have had in the last year.

GENERAL SYMPTOMS

- ❑ Food Allergy(What) ____ _________________
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection

- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dry Skin
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge

MUSCLES & JOINTS

- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Pregnant Now?

DO YOU HAVE OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles	
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder	
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes	
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease		❑HIV Positive

---

List any other medical problems, illness, injuries or fractures you have had:
____

Do you wear any orthotics, heel lifts, braces or supports?
Explain: ____

When was your last exam? Please give approximate date and Dr. name

Physical Exam ____________________________ Dental Exam _______________________________

Eye Exam ________________________________ Pap / Prostate _____________________________

Do you have episodes of dizziness, fainting, disorientation or slurred speech? _____yes _____no

Family History

	Mother	Father	Sibling(s)
Stroke			
Diabetes			
Heart Disease			
Genetic Disease			
Cancer			
Other (please list)			

Social History

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _______

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _______

❑do not drink alcohol ❑do not smoke

Exercise ❑None ❑Moderate ❑Daily

Are you on any special diet? Explain: ____

What types of exercise do you do daily? ____

Smoking Status (circle only 1)

A.) Current Every Day Smoker Approximate Start Date: __________

(If applicable) In an effort to quit smoking, I am currently ____________________________

B.) Current Some Day Smoker

(If applicable) In an effort to quit smoking, I am currently ____________________________

C.) Former Smoker Approximate Start Date: __________ End Date: __________

D.) Never Smoker

Work Patterns

Occupation: ______________________________________ Hours/week? _____________________

How many hours of the day do you spend . . .

Sitting? __________ Standing? __________ Doing overhead arm work? _________

Bent forward? __________ Looking Down? __________ At a computer? __________

What is the average weight of the objects you lift each day? __________lbs

How many times per day do you lift these objects? __________times/day

Are you currently taking any medications? Yes No

Medication Name: ________________________ Medication Name: ________________________________

Medication Name: ________________________ Medication Name: ________________________________

Medication Name: ________________________ Medication Name: ________________________________

Are you currently taking any vitamins or supplements? Yes No
If Yes, please list:

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Do you have any allergies to medication? Yes No

Medication Name: ______________________ Medication Name: _____________________________

Medication Name: ______________________ Medication Name: _____________________________

Surgical History

Have you ever had any surgeries? ❑Yes ❑No

If yes, please enter the approximate year of surgery. (Use subsequent lines to note any surgeries not listed.)

Disc repair	_______	Spinal fusion	_______
Hip replacement	_______	Knee replacement	_______
Tonsillectomy	_______	Appendectomy	_______
Gall Bladder Removal	_______	Prostate Surgery	_______
Stomach Surgery	_______	Heart Surgery	_______
Breast Surgery	_______	Ovary Removal	_______
Hysterectomy	_______	Cesarean Section	_______
Hernia Repair	_______	Varicose Vein Surgery	_______
Carpal Tunnel Surgery	_______	Thyroid Surgery	_______
Joint Replacement	_______		

Please indicate your normal use of the items below

	Never	x/month	x/week	x/day
Sweets				
Processed Food				
Regular Soda				
Diet Soda				
Coffee				
Dairy				
Fresh Vegetable				
Tobacco				
Illicit Drugs				