ELEVATE CHIROPRACTIC
JIMMY SAYEGH CHIROPRACTIC CORP.

PATIENT INFORMATION:

First Name: __________________________ M.I. ___________ Last Name: ______________________________

Address: ____

City: _______________________ State: _________ Zip: _____________ Phone: (________) ______________

Sex: M ☐ F ☐ DOB: _____/_____/_____ Age: _______ Marital Status: M ☐ S ☐ D ☐

Social Security # ______ - ____ - _______ Cell: (________) ______________ Email: ____________________

Do you wish to receive text message or email appointment reminders? Y ☐ N ☐ Cell Carrier: ___________

Why did you choose our office? ____
How did you find our office? ____

Appointment Date: _____/_____/_____ Appointment time: ______ : ________ ☐ AM ☐ PM

EMPLOYER:

Name: ____ Occupation: __________________________________

Address: ____

City: _______________________ State: _________ Zip: _____________ Phone: (________) ______________

AUTO/INSURANCE CARRIER: ____

Claim #: ____________________________________ Policy #: ____

Insured First Name: ___________________________ M.I. _______ Last Name: _____________________________

Sex: M ☐ F ☐ DOB: _____/_____/_____

Do you have medical payment/bodily injury liability? ☐ Yes ☐ No

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IS THIS INJURY A(N): ☐ Auto Accident ☐ On-the-job Injury ☐ Other

Date of injury: _____/_____/_____ **Time of Injury:** ______ : ________ ☐ AM ☐ PM

PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A LEGAL GUARDIAN

Jimmy Sayegh, DC. 11879 Sebastian Way., Suite 103, Rancho Cucamonga CA 91730

HEALTH HISTORY FORM

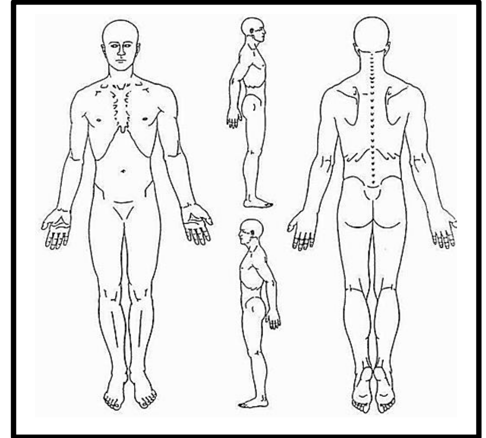
Name: ____ Date: _____________________

REASON FOR VISIT

List your chief complaint: ____
____
____

DRAW PAIN AREAS BELOW ↓

XXX = PAIN O = NUMBNESS/TINGLING



When did your pain begin? ___________________________________

How did it occur? ☐ Instantly ☐ Gradually ☐ Suddenly

Describe how your pain occurred: _____________________________
____
____

Is it: ☐Worse ☐Better : ☐Constant ☐frequent ☐Occasional ☐Intermittent

Have you had this or similar problems in the past? ☐ Yes ☐ No

When is your pain worse? ☐ Morning ☐ Afternoon ☐ Nighttime

On a scale of 0 to 10, 10 = extreme pain, 0 = no pain, rate your pain

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

What makes it worse? ______________________________________

What makes it better? ______________________________________

Do you have any pain/numbness in arms, hands, legs or feet?

☐ Yes ☐ No Where and what type? ______________________

Have you seen any other doctors for this problem? ☐ Yes ☐ No

If yes, doctors name: ____

What type of physician? ☐ Chiropractic ☐ Medical ☐ Other Most recent visit date: _________________

PAST MEDICAL HISTORY:

Medications: ☐ Pain killers ☐ Muscle relaxers ☐ Blood pressure ☐ Other: ____________________________

List all surgeries you have had and when: ____
____

Prior Injuries (Please check all that apply):

☐ Head ☐ Spine ☐ Pelvis ☐ Arm ☐ Elbow ☐ Wrist ☐ Hand ☐ Finger ☐ Hip ☐ Knee

☐ Ankle ☐ Foot ☐ Toe *When?* _________________________ *Type of injury:* _________________________

Describe your injuries: ____
____

Are you still under care for your previous injuries? ☐ Yes ☐ No *If yes, where?:* _________________________

Do any of your previous injuries still bother you? ☐ Yes ☐ No

AUTO ACCIDENT HISTORY:

Last auto accident: ☐ Past year ☐ Past 5 years ☐ Over five years ☐ Never

Auto Accident type: ☐ Rear ended ☐ Head on ☐ T-Boned ☐ other: __________________________________

Did you sustain any injuries *(List all)*: ____

Did you receive any treatment? ☐ Yes ☐ No Where? ____

Have you ever experienced loss of consciousness? If so, describe: ______________________________________
____

YOUR HEALTH HISTORY

Please mark all that apply: **C = Current, P = Past**

General
- C ☐ P ☐ Allergies
- C ☐ P ☐ Convulsions
- C ☐ P ☐ Dizziness
- C ☐ P ☐ Fainting
- C ☐ P ☐ Headaches

Constitutional
- C ☐ P ☐ Fevers/chills/sweats
- C ☐ P ☐ Unexplained weight loss
- C ☐ P ☐ Unexplained weight gain
- C ☐ P ☐ Fatigue/ weakness
- C ☐ P ☐ Decreased Appetite
- C ☐ P ☐ Difficulty w/ Sleeping

EENT
- C ☐ P ☐ Vision problems
- C ☐ P ☐ Difficulty hearing
- C ☐ P ☐ Ringing in ears
- C ☐ P ☐ Sinus problems
- C ☐ P ☐ Nose bleeds
- C ☐ P ☐ Throat infection

Intestinal
- C ☐ P ☐ Abdominal pain
- C ☐ P ☐ Heartburn
- C ☐ P ☐ Blood/black bowel
- C ☐ P ☐ Irritable bowel syndrome
- C ☐ P ☐ Constipation
- C ☐ P ☐ Nausea/Vomiting
- C ☐ P ☐ Diarrhea
- C ☐ P ☐ Gall Bladder problems
- C ☐ P ☐ Hemorrhoids
- C ☐ P ☐ Liver problems
- C ☐ P ☐ Colon problems
- C ☐ P ☐ Hernia

Cardiovascular
- C ☐ P ☐ Heart Disease
- C ☐ P ☐ High blood pressure
- C ☐ P ☐ Chest pain/tightness
- C ☐ P ☐ Irregular heart beat
- C ☐ P ☐ Swelling of legs/ankles

Respiratory
- C ☐ P ☐ Asthma
- C ☐ P ☐ Chest pain
- C ☐ P ☐ Chronic cough
- C ☐ P ☐ Difficulty breathing

Urinary
- C ☐ P ☐ Night time urination
- C ☐ P ☐ Leaking urine
- C ☐ P ☐ Painful urination
- C ☐ P ☐ Blood in urine
- C ☐ P ☐ Frequent urination
- C ☐ P ☐ Kidney infection
- C ☐ P ☐ Prostate problems

Muscle & Joint
- C ☐ P ☐ Arthritis
- C ☐ P ☐ Osteopenia or Osteoporosis
- C ☐ P ☐ Joint pain/stiffness

Skin
- C ☐ P ☐ Bruise easily
- C ☐ P ☐ Hives or Allergy
- C ☐ P ☐ Skin Rash

Neurological
- C ☐ P ☐ Numbness
- C ☐ P ☐ Memory loss
- C ☐ P ☐ Loss of coordination
- C ☐ P ☐ Loss of balance

Blood/Lymphatic
- C ☐ P ☐ Unexplained lumps
- C ☐ P ☐ Excessive bleeding

Women Only
- C ☐ P ☐ Cramps w/ backaches
- C ☐ P ☐ Excessive menstrual
- C ☐ P ☐ Irregular cycle
- C ☐ P ☐ Lumps in breasts
- C ☐ P ☐ Post-menopausal

Psychiatric/social
- C ☐ P ☐ Anxiety/stress
- C ☐ P ☐ Depression
- C ☐ P ☐ Chronic Fatigue
- C ☐ P ☐ Drugs
- C ☐ P ☐ Alcohol
- C ☐ P ☐ Smoking

Other:
- C ☐ P ☐ Diabetes
- C ☐ P ☐ Cholesterol problem
- C ☐ P ☐ Alcoholism
- C ☐ P ☐ Anemia
- C ☐ P ☐ Cancer: ____________
- C ☐ P ☐ Measles
- C ☐ P ☐ Stroke
- C ☐ P ☐ Blood coagulation
- C ☐ P ☐ Rheumatic Fever
- C ☐ P ☐ STD's
- C ☐ P ☐ Gout
- C ☐ P ☐ Mumps
- C ☐ P ☐ Polio
- C ☐ P ☐ Other: ____________________

____

FAMILY HEALTH HISTORY

Many health problems have familial tendencies. Information about family members will give us a better picture of your total health.

NAME **RELATION** **PAST & PRESENT HEALTH PROBLEMS**

____

____

____

FOR WOMEN ONLY:

☐ This is to certify to the best of my knowledge that I am **not** pregnant and the treating doctor and his/her associates have my permission to perform chiropractic modalities as well as any x-ray evaluations necessary. I have been advised that certain modalities or x-ray exams can be hazardous to an unborn child.

☐ This is to certify that I **am** in fact pregnant and do not wish to partake in any diagnostic/therapeutic procedures or x-rays that may cause harm to my unborn child.

Date of my last menstrual period: ________/________/________ **or** I am _______________ weeks into my pregnancy

INCASE OF EMERGENCY: *(Please provide a name of a friend or relative we can contact in case of an emergency)*

Name: ____ Relationship: ______________________

Address: ____ Phone #: __________________________

Patient Signature: ____ Date: _______________________

Legal Guardian Signature: _____________________________________ Date: _______________________

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME ____________________ DATE __________

SCORE ______ [60] BENCHMARK = 5 ____________

SIGNATURE: ____________________