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: ____________________

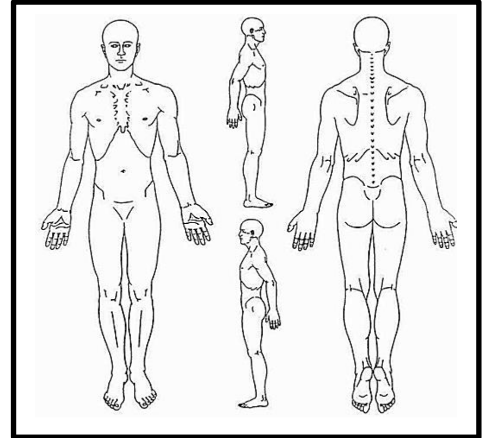
REASON FOR VISIT

List your chief complaint: ____
____
____

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? _____________________

DRAW PAIN AREAS BELOW ↓
XXX = PAIN O = NUMBNESS/TINGLING



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: ___________________________________
____

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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: ______________________

AUTO ACCIDENT HISTORY:

PLEASE DESCRIBE YOUR ACCIDENT:

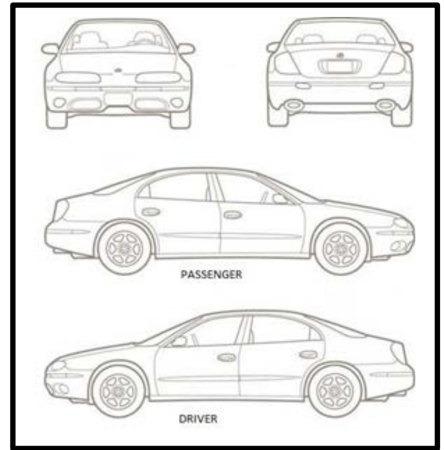
ABOUT YOUR ACCIDENT:

Date of your accident: ________________________

Was your accident? ☐ Rear ended ☐ Head on ☐ T-Boned ☐ other: ___________________________________

Were you? ☐ Driver ☐ Passenger *in:* ☐ Front seat ☐ Back seat (R / M / L)

SHADE IN DAMAGE AREAS ↓



Your car: Year: __________ Make: _____________ Model: _____________

Other car: ☐ Small ☐ Mid-size ☐ Large ☐ Unknown

ABOUT YOUR INJURIES: *(Please answer the following about your injuries):*

Did you feel pain immediately? ☐ Yes ☐ No

Did you feel: ☐ Dizziness ☐ Nausea/Vomiting

Were you surprised by the impact? ☐ Yes ☐ No

Were you able to brace for impact? ☐ Yes ☐ No

Did your head strike anything? ☐ Yes ☐ No

Describe: ____

Were you rendered unconscious? ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No

If yes, When? _______________ Where? ____

Did they perform any: ☐ X-rays ☐ MRI ☐ CT-Scan ☐ Other: ____

Was medication prescribed by the hospital? ☐ Yes ☐ No

List: ____

Did you see a flash of light upon impact? ☐ Yes ☐ No

Did your airbag deploy? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Where was your head facing at the time of impact? ☐ Left ☐ Forward ☐ Right ☐ Unknown

Were you leaning forward at the time of the impact? ☐ Yes ☐ No

In relation to the back of your head, was your head rest: ☐ Low ☐ Middle ☐ High

Did you lose time off of work? ☐ Yes ☐ No How many days? _________________

Are you suffering from any of the following after the accident? ☐ Anxiety ☐ Sleeping problems ☐ Depression

Have you seen any of the following for your injuries:? ☐ Urgent Care ☐ Primary Care Physician ☐ Chiropractor ☐ Physical Therapist ☐ Acupuncture ☐ Massage Therapist ☐ Ortho ☐ Neuro ☐ Pain Management ☐ Other: _________________________

List Where/Who: ____

GENERAL INFORMATION:

Did you get a property damage estimate for your vehicle? ☐ Yes ☐ No Estimate: $____________________

Do you have a copy of the police report? ☐ Yes ☐ No

CONSENT FOR TREATMENT OF A MINOR:

☐ I hereby consent to any chiropractic treatment deem necessary to named minor above.

Patient Signature: ____ Date: ________________________

Legal Guardian Signature: ____ Date: ________________________

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ACTIVITIES OF DAILY LIVING ENJOYMENT LOSS

Patient Name: ____ File #: ______________

Please check **all** activities of daily living that cause you pain due to your injuries.

- ☐ Dressing
- ☐ Putting on pants
- ☐ Tying my shoes
- ☐ Putting on my shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Lying in bed
- ☐ Sleeping
- ☐ Traveling
- ☐ Going out with friends
- ☐ Riding in the car
- ☐ Driving a car
- ☐ Opening a jar
- ☐ Cooking
- ☐ Lifting a pan when cooking
- ☐ Cleaning the house
- ☐ General chores
- ☐ Closing the trunk of my car
- ☐ Using my computer
- ☐ Using my cell phone/tablet
- ☐ Climbing stairs
- ☐ Going down stairs
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Grocery shopping
- ☐ Sitting in church
- ☐ Playing with my children/grandchildren
- ☐ Caring for my children/grandchildren
- ☐ Bending over
- ☐ Sitting at a movie theater
- ☐ Exercising
- ☐ Playing sports
- ☐ Eating
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Shopping
- ☐ Sexual Activity
- ☐ Watching TV
- ☐ Reading
- ☐ Sitting at the dinner table
- ☐ Hiking
- ☐ Attending my children's after school activities
- ☐ Doing my homework
- ☐ Sitting in class
- ☐ Paying attention in class

Other:

- ☐ ________________________
- ☐ ________________________
- ☐ ________________________

Patient Signature: ____

Date: ______________________________