

Back to Health Chiropractic Center
Dr. Carolyn Griffin, D.C.

Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Home Ph _____ Cell Ph _____ Work Ph _____ E-mail: _____

SSN _____ - _____ - _____ Date of Birth _____ Age _____ Height _____ Weight _____ Male Female

Single Married Divorced Widowed # of Children _____ Name of Spouse (or parent) _____ Cell Ph _____

Occupation _____ Employer _____

Address _____ City _____ State _____ Zip _____

How did you hear about our office? Yellow pages Saw sign Magazine Family / Friend _____ Expo Other _____

What is the name of your family physician? _____ What city are they located in? _____

Have you ever had Chiropractic care before? _____ If yes, doctor name: _____ Date of last visit _____

If you are experiencing any pain (neck, mid back, low back pain, etc.) health problems or other symptoms/complaints, please list in order of severity:

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

4. _____ For how long? _____

List other doctors consulted for this/these conditions:

1. _____ Address: _____

2. _____ Address: _____

Is this injury or illness work related? _____ **Yes** _____ **No** Have you reported it to your employer? _____

Have you been involved in an auto accident in the last 12 months? _____ **Yes** _____ **No** If yes, what is the date of the auto accident? _____

Do you have an attorney representing you for this auto accident? _____ **Yes** _____ **No** If yes, who is your attorney? _____

How many other passengers were in the car with you? _____ What is the name of your auto insurance company? _____

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

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any **current or past injuries** and illnesses not listed above: _____

Please check all medications (over-the-counter and/or prescribed) you are currently taking: Aspirin/Tylenol Pain killers Muscle Relaxers Insulin

Birth Control Pills Sleeping pills Anti-Depressants Others _____

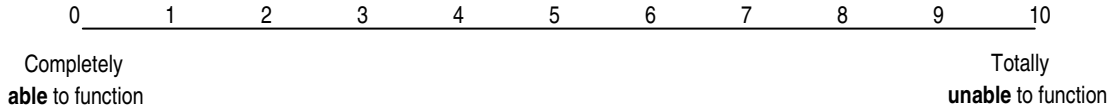
Health Insurance Co. Name _____ Policyholder _____

Name of Spouse's health insurance (If applicable) _____ Policyholder _____

Spouse's Health Insurance Claims address _____ Policy number _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health conditions (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

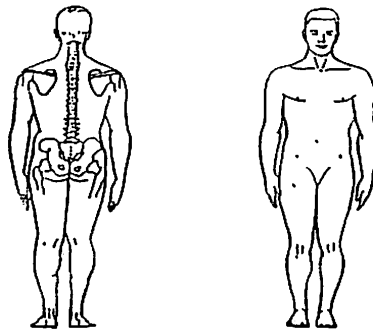
For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).



1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____
2. RECREATION: hobbies, sports, and other similar leisure time activities. _____
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer work. _____
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: Cash Check Credit card _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. 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's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____