CONFIDENTIAL PATIENT CASE HISTORY

WELCOME TO OUR OFFICE! Douglas DeSalvo DC, BCIN 7595 Redwood Blvd. Ste. 108 Novato, CA 94945
Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

PERSONAL INFORMATION

Name:_____ Date:_____

Date of Birth:_____/_____/_____ Age:_____ Sex: ❑ Male ❑ Female Marital Status: S / M / D / W

Address:_____ City:_____ State:_____ Zip:_____

Social Security #:_____-_____-_____ Home Phone:(_____) _____-_____

Cell Phone:(_____)_____-_____ E-mail:_____

Occupation:_____ Employer:_____

Employer Address:_____ Work Phone:(_____)_____-_____

Spouse's Name:_____ Date of Birth:_____ Age:_____

Employer Address:_____ Work Phone:(_____)_____-_____

Social Security #:_____-_____-_____ How Many Children (Ages)?:_____

Emergency Contact:_____ Phone:(_____) _____-_____

Who Referred You To Us?:_____

How Else Did You Hear About Us?:_____

CURRENT PRIMARY HEALTH CONCERN

What is your main symptom?:_____

How long have you had this condition?:_____

Have you had this or similar conditions in the past?:_____

What do you think caused this condition?:_____

What position(s), if any, make it feel worse?:_____

What position(s), if any, make it feel better?:_____

Over time, is this condition: ❑ Improving ❑ Unchanged ❑ Getting Worse?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine Other:_____

Have you sought advice or treatment from other doctors or therapists for ***this*** condition? ❑ Yes ❑ No

If yes, list all doctors or therapists consulted for this condition (include approximate date of visit and diagnosis).

Name	Date of visit	Diagnosis

Describe any treatment you have had for ***this*** condition (include medication dosage and frequency)?:_____

_____

_____

Family Medical Doctor:_____ Address:_____ Date of Last Physical:_____

May we communicate our findings on your current health condition to the above provider(s)? ❑ Yes ❑ No

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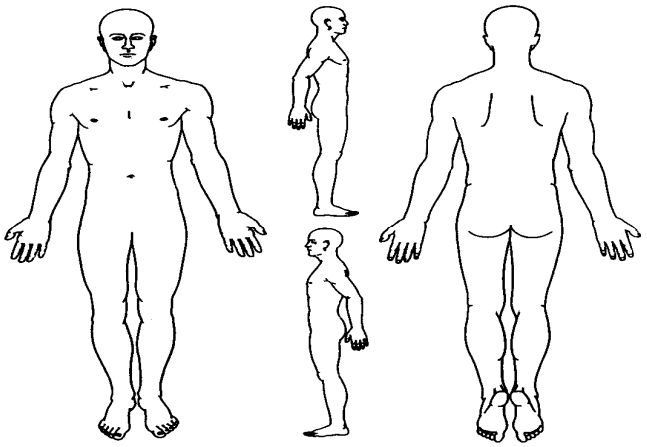
Patient Name:_____ Date:_____

OTHER HEALTH COMPLAINTS

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.



Primary Complaint:

1) _____ 1 2 3 4 5 6 7 8 9 10

Additional Complaints:

2) _____ 1 2 3 4 5 6 7 8 9 10

3) _____ 1 2 3 4 5 6 7 8 9 10

4) _____ 1 2 3 4 5 6 7 8 9 10

5) _____ 1 2 3 4 5 6 7 8 9 10

PREVIOUS CONDITIONS

Days Lost From Work:_____ Date of Last Physical Examination: _____

Have you sought care for another health condition in the past year? ❑ Yes ❑ No Past 2 years? ❑ Yes ❑ No

If yes, what condition other than your primary complaint?:_____

Was treatment administered? ❑ Yes ❑ No Describe: _____

_____

Do you take medications? ❑ Yes ❑ No List Dosage, Frequency and Reason:_____

_____

_____

Any prior hospitalizations or surgery? ❑ Yes ❑ No Describe with dates:_____

_____

Have you been in an auto accident or had any other personal injury? ❑ Yes ❑ No Describe:_____

_____

CHIROPRACTIC HISTORY

Previous Chiropractic care? ❑ Yes ❑ No If yes, Doctor's name:_____

Date of last chiropractic visit: _____/_____/_____ Date of last chiropractic X-rays:_____/_____/_____

Reason for care:_____ How long were you under care?: _____

Were you satisfied with the previous chiropractic care you received? ❑ Yes ❑ No

Are other family members under chiropractic care? ❑ Yes ❑ No Who?: _____

Are you open to looking at new ideas in health and wellness? ❑ Yes ❑ No

SOCIAL HISTORY

Height:_____ft. _____in. Current Weight:_____ lbs. Have you recently lost or gained more than 10 lbs.? Y N

Mental Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:_____

Physical Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:_____

Exercise: ❑ Heavy ❑ Moderate ❑ Light Hours per week:_____ Type:_____

Smoking: ❑ Never ❑ Currently ❑ Previously Packs/day:_____, Pack/week:_____ How long?:_____

Alcohol: Beer/week:_____, Liquor/week:_____, Wine/week:_____ How long?:_____

Caffeine: Cups/day:_____ How long?:_____ Aspirin: No./day:_____ How long?:_____

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

REVIEW OF SYSTEMS (NOW=within the past 1 year; PAST=over one year ago)

GENERAL	Now	Past
Weakness	❑	❑
Fatigue	❑	❑
Fever	❑	❑
Chills	❑	❑
Night Sweats	❑	❑
Fainting	❑	❑
SKIN		
Color Changes	❑	❑
Nail Changes	❑	❑
Hair Changes	❑	❑
Moles	❑	❑
Rashes	❑	❑
Sores	❑	❑
Weakness	❑	❑
HEAD & EYES		
Headaches	❑	❑
Injuries	❑	❑
Bumps	❑	❑
Last Eye Exam	❑	❑
Glasses	❑	❑
Contacts	❑	❑
Cataracts	❑	❑
EARS		
Hard of Hearing	❑	❑
Deafness	❑	❑
Ringing	❑	❑
Discharge	❑	❑
Earache	❑	❑
Itching	❑	❑
Dizziness	❑	❑
Room Spins	❑	❑
NOSE		
Decreased Smell	❑	❑
Bleeding	❑	❑
Pain	❑	❑
Discharge	❑	❑
Obstruction	❑	❑
Post Nasal Drip	❑	❑
Deviated Septum	❑	❑
Runny Nose	❑	❑
Sinus Congestion	❑	❑
MOUTH		
Bleeding Gums	❑	❑
Sores	❑	❑
Dental Problems	❑	❑
Bad Breath	❑	❑
Loss of Taste	❑	❑
Dry Mouth	❑	❑
Ulcers	❑	❑
Blisters	❑	❑
THROAT		
Soreness	❑	❑
Bad Tonsils	❑	❑
Hoarseness	❑	❑
Pain	❑	❑
Trouble Swallowing	❑	❑
Recurrent Infections	❑	❑
NECK		
Neck Enlargement	❑	❑
Stiff Neck	❑	❑
Soreness	❑	❑
Lumps	❑	❑
Masses	❑	❑

BREASTS	Now	Past
Discharge	❑	❑
Lumps	❑	❑
Pain	❑	❑
Bleeding	❑	❑
Nipple Changes	❑	❑
Skin Changes	❑	❑
Bloated	❑	❑
RESPIRATORY		
Cough	❑	❑
Phlegm	❑	❑
Blood	❑	❑
Short of Breath	❑	❑
Wheezing	❑	❑
Pain	❑	❑
Congestion	❑	❑
Inhalant exposure	❑	❑
CARDIOVASCULAR		
Murmur	❑	❑
Palpitations	❑	❑
Rapid Heartbeat	❑	❑
Swollen Extremities	❑	❑
Cold Extremities	❑	❑
Chest Pain,Pressure	❑	❑
Varicose Veins	❑	❑
Blood Clots	❑	❑
Blue Extremities	❑	❑
BLOOD		
Anemia	❑	❑
Low Blood Iron	❑	❑
Easy Bruising	❑	❑
Easy Bleeding	❑	❑
Swollen Nodes	❑	❑
Painful Nodes	❑	❑
Sugar in Blood	❑	❑
Red Spots	❑	❑
GASTROINTESTINAL		
Abdominal Pain	❑	❑
Nausea	❑	❑
Bloated	❑	❑
Belching	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Irreg. Bowel Habits	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Gas	❑	❑
Hemorrhoids	❑	❑
Poor Appetite	❑	❑
Food Intolerance	❑	❑
Bloody Stools	❑	❑
Black Stools	❑	❑
GENITOURINARY		
Urgency	❑	❑
Incontinence	❑	❑
Straining	❑	❑
Back Pain	❑	❑
Frequent Voiding	❑	❑
Stones	❑	❑
Burning	❑	❑
Bed Wetting	❑	❑
Small Stream	❑	❑
Discharge	❑	❑
Impotence	❑	❑

GENITOURINARY	Now	Past
Dribbling	❑	❑
Cloudy Urine	❑	❑
Spotting	❑	❑
Menstrual Cramps	❑	❑
Painful Menses	❑	❑
Itching	❑	❑
Painful Intercourse	❑	❑
Irregular Periods	❑	❑
Hot Flashes	❑	❑
NEUROLOGICAL		
Seizures	❑	❑
Vertigo	❑	❑
Dizziness	❑	❑
Hand Trembling	❑	❑
Loss of Sensation	❑	❑
Incoordination	❑	❑
Loss of Facial	❑	❑
Weak Grip	❑	❑
Paralysis	❑	❑
Difficulty Speech	❑	❑
Tingling	❑	❑
Loss of Memory	❑	❑
Numbness	❑	❑
ENDOCRINE		
Weight Loss	❑	❑
Weight Gain	❑	❑
Extremely Thin	❑	❑
Heat Intolerance	❑	❑
Cold Intolerance	❑	❑
Hair Changes	❑	❑
Breast Changes	❑	❑
IMMUNIZATION/VACCINATION		
DPT	❑	❑
Mumps	❑	❑
Smallpox	❑	❑
Typhoid	❑	❑
Tetanus	❑	❑
Measles	❑	❑
Pneumococcal	❑	❑
Influenza	❑	❑
Polio	❑	❑
MMR	❑	❑
PSYCHIATRIC		
Hyperventilation	❑	❑
Insecurity	❑	❑
Depression	❑	❑
Troubles Sleep	❑	❑
Irritable	❑	❑
Hallucinations	❑	❑
Loss of Memory	❑	❑
Alcoholism	❑	❑
Drug Addiction	❑	❑
Drug Dependent	❑	❑
Suicidal Thoughts	❑	❑
Extreme Worry	❑	❑
Sexual Problems	❑	❑
MUSCULOSKELETAL		
Muscle Pain	❑	❑
Muscle Weakness	❑	❑
Muscle Cramps	❑	❑
Muscle Stiffness	❑	❑
Joint Stiffness	❑	❑
Joint Pain	❑	❑

PAST MEDICAL HISTORY

Check only the ones you have had in the past.

Hay Fever	❑
Mumps	❑
Rheumatic Fever	❑
Allergies	❑
Angina	❑
Cancer	❑
Tumor	❑
Blood Disease	❑
Leukemia	❑
Heart Trouble	❑
Varicose Veins	❑
Phlebitis	❑
Hypertension	❑
Stroke	❑
Ulcers	❑
Jaundice	❑
Skin Trouble	❑
Gallstones	❑
Liver Trouble	❑
Hepatitis	❑
Parasites	❑
Epilepsy	❑
Paralysis	❑
Polio	❑
Mental Illness	❑
Alcoholism	❑
Depression	❑
Nervous Breakdown	❑
Migraine	❑
Gout	❑
Hemorrhoids	❑
Prostate Problems	❑
Sexual Problems	❑
Gonorrhea	❑
Syphilis	❑
Diabetes	❑
Bladder Trouble	❑
Kidney Stones	❑
Kidney Infections	❑
Dysentery	❑

ALLERGIES

List known allergies below

_____
_____
_____
_____
_____
_____
_____

If Female,
Are You Pregnant?

❑ **Yes**
❑ **No**

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

FAMILY HISTORY - List any of the diseases listed previously which run in your family

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses (if any)
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____	_____
Grandfather (Mat):	_____	_____	_____	_____	_____
Grandmother (Mat):	_____	_____	_____	_____	_____
Grandfather (Pat):	_____	_____	_____	_____	_____
Grandmother (Pat):	_____	_____	_____	_____	_____

Spouses Health Status: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Children's ages and health status:_____

_____

INSURANCE INFORMATION

Who is responsible for this account?: _____

Relationship to Patient?: _____ Social Security No: _____-_____-_____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

Is patient covered by additional or secondary insurance? ❑ Yes ❑ No

Subscriber's Name: _____

Relationship to Patient?: _____ Birth Date: _____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

ASSIGNMENT AND RELEASE

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or this office to contact me via mail, email and phone in regards to treatment as well as promotional activities. This clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I have also received a copy of this office's Financial Policy and Appointment Policy and agree to its terms.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)