VALUSEK CHIROPRACTIC GROUP **(760) 352-1452 FAX (760) 352-3966** **1073 Ross Avenue, Suite B, El Centro, CA 92243**

PATIENT CASE HISTORY

Name_______________________________ Date of Birth_______________ Gender __________

Who may we thank for referring you to our office?_______________________________

Social Security No.____________________ Marital Status__________ Job Title_______________

Do you smoke? __________ have you ever smoked?__________ If you currently smoke, how frequently? __________

Address ______________________________ City __________________ State______ Zip ________

Home phone_______________________ Work phone____________________ Preferred phone__________

Cell phone__________________________ Fax _______________________________

E-mail ____________________________ Driver's license number ______________________

Employer name and address____

Spouse's employer______________________________ Phone number___________________

Emergency contact______________________ Home phone_______________ Work phone__________

Address_________________________ City ____________ State ____Cell phone_______________

Next of kin______________________________ relationship to patient___________________

Address _________________________________ Home phone_________________________

Cell phone________________________ work phone_______________________________

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO ID TO THE RECEPTIONIST FOR COPYING

Who is primary insured on insurance policy ________________Date of birth_________ Relationship to patient__________

Family physician ______________________________ Phone number___________________

Is this condition work related? _____yes _____no

Where were you when this condition started? ☐ at work ☐ at home ☐ auto accident ☐ other (describe)_______________

What were you doing at the time____

How long have you had this present pain? ____hours ____ days ____ weeks ____ months

Did your pain begin gradually? ☐ yes ☐ no Suddenly? ☐ yes ☐ no date?_______________

Is pain ☐ continuous? ☐ off and on ? ☐ getting worse?

Have you had this or similar condition before? ☐ yes ☐ no If yes, when?____________________

X-RAY HISTORY:

Have you had any X-rays taken in the past six months? ☐ Yes ☐ No If yes, where were they taken?______________

Name of doctor requesting x-rays______________________Part of the body X-rayed?________________

How long have you been off work and/or unable to do normal activities at home?____________________

Have you ever been in the hospital for ☐ back ☐ neck ☐ leg problems? When?____________________

Have you ever had back or neck surgery? ☐ yes ☐ no If yes, when?____________________

REGARDING INSURANCE: We will give you an insurance receipt (or bill your insurance company if you direct us to do so). Insurance policies are arrangements between the carrier and the patient and often are not designed to take care of the entire amount necessary for the care of their condition. Patients who carry Health and Accident Insurance should know that all professional services are charged directly to the patient and that he or she is personally responsible for payment.

PAYMENT FOR SERVICES IS DUE WHEN RENDERED. IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE GIVE 24 HOUR NOTICE TO AVOID BEING CHARGED THE $30 MISSED OR LATE APPOINTMENT FEE.

I do hereby certify that the preceding questions have been answered truthfully and completely to the best of my knowledge and belief.

____

Patient's signature (if patient is a minor, signature of parent or guardian)

PLEASE COMPLETE IF YOU WANT THIS OFFICE TO SEND THE INSURANCE RECEIPT DIRECTLY TO YOUR INSURANCE COMPANY.
I authorize release of any information pertinent to my case to any insurance company involved in this case.

_______________________________________ Date_______________________

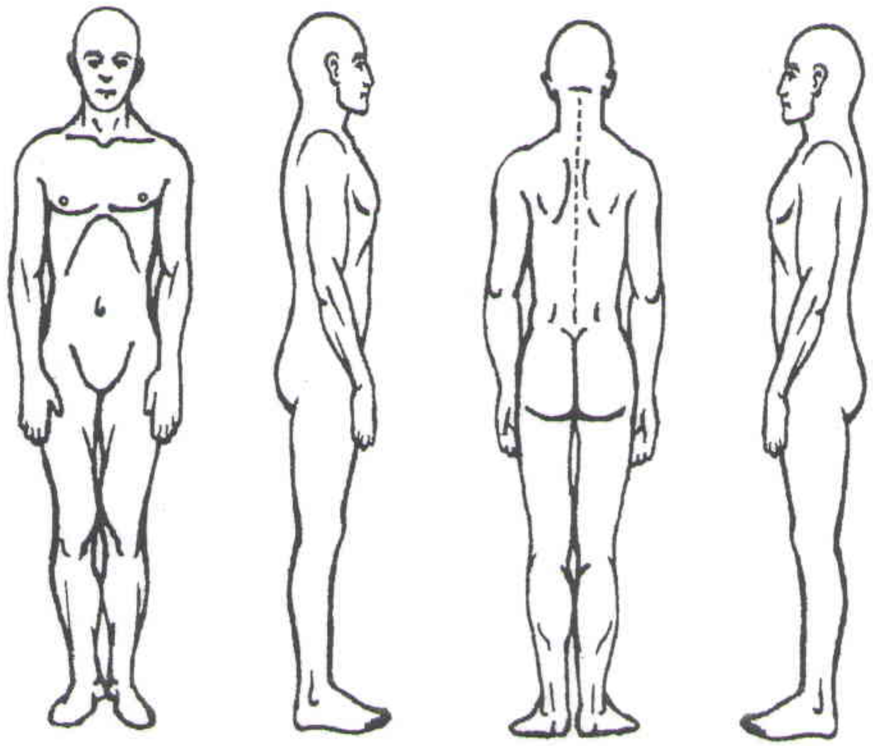
Signature of patient (if a minor, signature of parent or guardian)

WILLIAM P. VALUSEK, DC, FACO
MATTHEW J. VALUSEK, DC,
1073 Ross Avenue, Suite B, El Centro, CA 92243

INITIAL PROBLEM RECORD

Name:____

Please mark your areas of complaint on the diagrams below using the symbols on the right.



Aching ^^^
Numbness +++
Pins and Needles 000
Burning XXX
Stabbing or Sharp ///

What problem is your biggest concern?____________________________________

On the horizontal line below, draw a vertical line denoting the severity of your worst pain:

0	1	2	3	4	5	6	7	8	9	10
No pain	Minimal (annoyance)	Constant Minimal to Intermittent Slight	Constant slight (some handicap)	Constant slight to intermittent moderate	Constant slight to frequent moderate	Intermittent moderate (marked handicap)	Frequent moderate	Constant moderate severe	Constant Mod. to Intermittent Incapacitated)	Constant severe

How many days a week do you experience this problem? 1 2 3 4 5 6 7

What percentage of the time do you experience this problem <25% 25% 50% 75% 100%

If you have more than one problem, which is the next worst?________________________

Rate this pain in a similar fashion:

0	1	2	3	4	5	6	7	8	9	10
No pain	Minimal (annoyance)	Constant Minimal to Intermittent Slight	Constant slight (some handicap)	Constant slight to intermittent moderate	Constant slight to frequent moderate	Intermittent moderate (marked handicap)	Frequent moderate	Constant moderate	Constant Mod. to Intermittent severe	Constant severe Incapacitated)

Signature____________________________________ Date__________________________

* For the following conditions please check: ☐ for **previously** had, O for **presently** have.

General:

☐ O Alcoholism
☐ O Anemia
☐ O Cancer
☐ O High cholesterol
☐ O Diabetes
☐ O Epilepsy/Seizures
☐ O Thyroid

☐ O Gout
☐ O Hypoglycemia
☐ O Multiple sclerosis
☐ O Osteoarthritis
☐ O Parkinson's disease
☐ O Pneumonia
☐ O Polio

☐ O Rheumatic fever
☐ O Rheumatoid arthritis
☐ O Depression
☐ O Tuberculosis
☐ O Ulcers
☐ O Venereal Disease
☐ O Skin Problems

Resistance to infection:

☐ O Catch colds easily
☐ O Frequent sinus trouble
☐ O Frequent influenza

Gastrointestinal:

☐ O Gall bladder problem
☐ O Liver trouble/Hepatitis
☐ O Excessive thirst
☐ O Distress from greasy foods
☐ O Pain over Stomach
☐ O Burning in stomach relieved by eating
☐ O Burping or bloating (if bloating, where?)________________

☐ O Heartburn
☐ O Nausea
☐ O Diarrhea
☐ O Blood in stool
☐ O Metallic taste in mouth

☐ O Mucus in stool
☐ O Colitis
☐ O Hiatal hernia
☐ O Vomiting
☐ O Constipation
☐ O Recent weight gain
☐ O Recent weight loss

Cardiovascular:

☐ O Pain over heart
☐ O Heart attack
☐ O Swelling in ankles

☐ O Irregular heartbeat
☐ O Stroke
☐ O Shortness of breath on exertion

☐ O Low blood pressure
☐ O High blood pressure
☐ O Pressure over chest

Nervous System:

☐ O Dizziness/Lightheaded
☐ O Fainting
☐ O Discoordination
☐ O Memory loss

Eye, Ear, Nose and Throat:

☐ O Vision problems
☐ O Hearing loss
☐ O Ear pain
☐ O Ear noises

☐ O Dental problems
☐ O Nose bleeds
☐ O Difficulty breathing through nose
☐ O Difficult speech

☐ O Hoarseness
☐ O Sore throat

Urinary Tract:

☐ O Blood in urine
☐ O Inability to control urination
☐ O Painful urination
☐ O Bladder infection
☐ O Kidney stones

Respiratory:

☐ O Chest pain
☐ O Coughing up blood
☐ O Difficulty breathing
☐ O Shortness of breath
☐ O Allergies

☐ O Chronic cough
☐ O Spitting up phlegm
☐ O Emphysema
☐ O Asthma

Signature ______________________________ **Date** ______________

* For the following conditions please check: ☐ for **previously** had, O for **presently** have.

Women Only:

☐ O Irregular periods
☐ O Hot flashes
☐ O Vaginal discharge
☐ O Menopausal symptoms
☐ O Headaches with period
☐ O Menstrual cramps
☐ O Excessive flow
☐ O Hysterectomy
☐ O Premenstrual depression
☐ O Painful breasts
☐ O Lumps in breasts

Are you now or is there a chance you could be pregnant? ______yes _____no

Men Only:

☐ O Burning on urination
☐ O Prostate trouble
☐ O Feeling of incomplete bowel evacuation
☐ O Need to get up at night to urinate
☐ O Difficulty starting urine
☐ O Dripping after urination

Blood Sugar:

☐ O Irritable before meals
☐ O Get "shaky" if hungry
☐ O "Lightheaded" if meals delayed
☐ O Fatigue relieved by eating
☐ O Heart palpitates if meals are missed/delayed
☐ O Awaken after a few hours sleep, hard to get back to sleep
☐ O Moods of depression - "blues" or melancholy
☐ O Abnormal craving for sweets or snacks

Neuromusculoskeletal

☐ O Headaches
☐ O Upper extremity pain
☐ O Neck pain
☐ O Lower extremity pain
☐ O Low back pain
☐ O Tingling in hands or feet

Health Promotion Survey:

1. How are you sleeping?____________________
2. List any medications that you are taking and dosages:____________________
3. List any dietary supplements (vitamins, herbs) that you are taking regularly:____________________
4. Are you following a special diet?____________________
5. How many times a day do you usually eat?____________________
6. What is your exercise program?____________________
7. Do you drink alcohol?____________ Have other habits that affect your health?____________
8. Do you feel you are under stress?____________________

Signature____________________ Date____________