Diamond Head Chiropractic

3427 Waialae Ave. STE C • Honolulu, HI 96816

Date _____ **Name** _____

Address _____

City _____ **State** _____ **Zip** _____

Gender: □**Male** □**Female** **Marital status:** □**Single** □**Married** □**Divorced**

SSN# _____ **Date of birth** _____

Phone# _____ **Cell#** _____ **Fax#** _____

E-mail _____

How were you referred to our office? _____

Occupation/Student information:

Employment status: □**Full Time** □**Part Time** □**Retired** □**Other** _____

Employer _____ **Work#** _____ **Occupation** _____

College student: □**Full Time** □**Part Time**

Health Insurance:

Financially responsible party: □**Self** □**Spouse** □**Parent** □**Other** _____

Policy holder _____ **Policy number** _____

Claims address _____

Have you had Chiropractic care before? If yes, what occurred? _____

_____

If you are experiencing any pain and/or health problems, please list your top two chief complaints in order of severity (pain, symptoms, etc.)

1. _____

Location: □**Left** □**Right** □**Both** □**Center**

Severity: □**Mild** □**Mild to Moderate** □**Moderate** □**Moderate to severe** □ **Severe**

Frequency: □**Intermittent** □**Occasional** □**Frequent** □**Constant**

Are there any activities, incidents or events that may have caused this complaint? □**Yes** □**No**

If yes, please explain: _____

What activities or positions make your condition worse? _____

What activities or positions make your condition better? _____

What type of pain are you feeling? □**Achy** □**Dull** □**Sharp** □**Fiery** □**Throbbing**

Visually mark your pain scale? No Pain _____|_____ **Severe Pain**

Does your pain radiate anywhere else? □**Yes** □**No**

If yes, please explain: _____

What time of day is your pain more significant? □**Morning** □**Afternoon** □**Evening** □**During night** □**During activities**

What side affects occur due to your pain? □**Decreased Range of Motion** □ **Numbness** □**Tingling** □ **Increased sensitivity** □**Tightness**

2. _____

Location: □Left □Right □Both □Center

Severity: □Mild □Mild to Moderate □Moderate □Moderate to severe □Severe

Frequency: □Intermittent □Occasional □Frequent □Constant

Are there any activities, incidents or events that may have caused this complaint? □Yes □No

If yes, please explain: _____

What activities or positions make your condition worse? _____

What activities or positions make your condition better? _____

What type of pain are you feeling? □Achy □Dull □Sharp □Fiery □Throbbing

Visually mark your pain scale? No Pain _____|_____ Severe Pain

Does your pain travel anywhere? □Yes □No

If yes, please explain: _____

What time of day is your pain more significant? □Morning □Afternoon □Evening □During night □During activities

What side affects occur due to your pain? □Decreased Range of Motion □Numbness □Tingling □Increased sensitivity □Tightness

Patient History:

Name of family physician: _____

Address: _____ Last visit date: _____

List all hospitalizations and their dates: _____

Reasons: _____

Have you had any surgeries? □Yes □No

Last surgery date: _____ Reason: _____

List all fractures you have had and their dates: _____

List all dislocations you have had and their dates: _____

Past or Current Problems (Check all that apply)

□Autoimmune disorders	□Cancers/Tumors/Cyst	□Kidney disorders	□Diabetes
□Allergies	□Cardiovascular diseases	□Thyroid Conditions	□Liver disorders
□Anemia	□Viral/Bacteria (e.g. Polio)	□Reproductive problems	□ Vision problem
□Arthritis	□Gastrointestinal disorders	□Respiratory conditions	
□Asthmas	□Epilepsy/CNS/PNS	□Endocrine disorders	

Family History (Check all that apply)

□Autoimmune disorders	□Cancers/Tumors/Cyst	□Kidney disorders	□Diabetes
□Allergies	□Cardiovascular diseases	□Thyroid Conditions	□Liver disorders
□Anemia	□Viral/Bacteria (e.g. Polio)	□Reproductive problems	□ Vision problem
□Arthritis	□Gastrointestinal disorders	□Respiratory conditions	
□Asthmas	□Epilepsy/CNS/PNS	□Endocrine disorders	

Social History

Do you drink alcohol? □Yes □No **How many drinks/week?** _____

Do you smoke cigarettes? □Yes □No **How many packs/day?** _____

Do you drink coffee/caffeine? □Yes □No **How many drinks/day?** _____

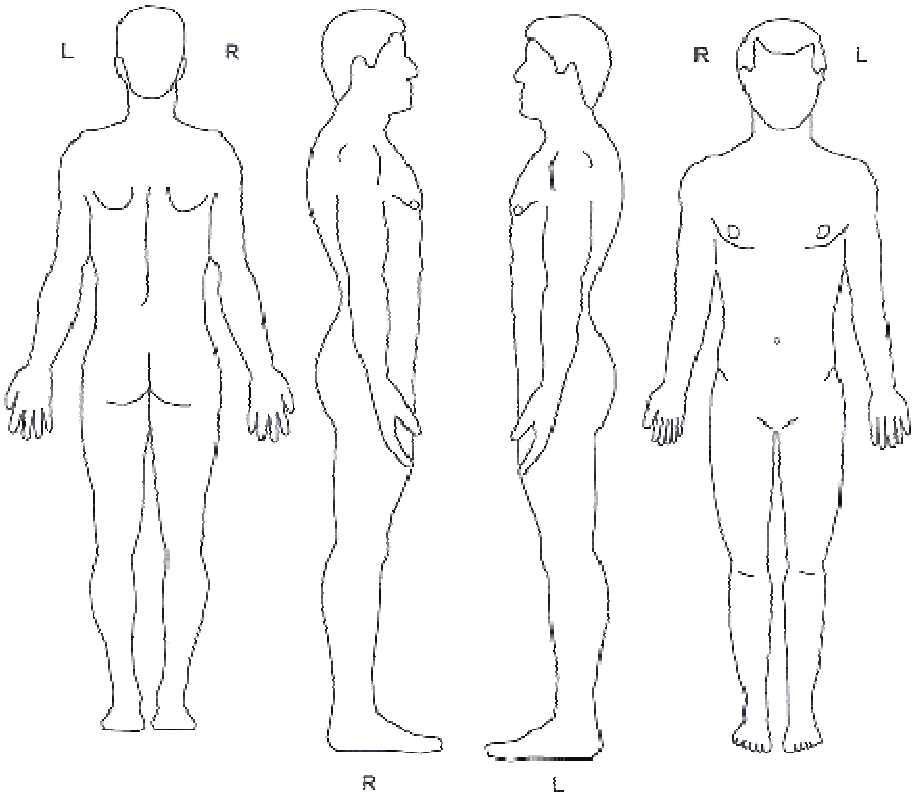
Do you exercise? □Yes □No **How many hours/week?** _____

Females Only

Last period date: _____

Birth Control: □Yes □No

Are you pregnant? □Yes □No



Please draw the location of your pain or discomfort on these images. Use the symbols shown below to represent the type(s) of pain:

D = Dull/Achy

B = Burning

N = Numb

S = Stabbing/Sharp

T = Tingling (Pins & Needles)

C = Cramping/Tight

Patient Signature_____ Date _____