MENDOZA CHIROPRACTIC

MICHAEL A. MENDOZA, D.C.

Patient Information Form

Date: / /

Name:		**DOB:** / /	**Age:**	**Gender:**	M / F
Address:					
City:	**State:**		**Zip:**		
Home: ( )	**Cell:** ( )		**Work:** ( )		
E-mail Address:					
Driver's License #:		**Social Security #:**			
Employer:		**Occupation:**			
Marital Status: Single	Married	Divorced	Widowed	Separated	
Name of Spouse:			**Number of Children:**		
Referred By (Please be specific):					
Emergency Contact(Name/Number):					
Relationship:					

CURRENT HEALTH CONDITION

Purpose of this visit:			**When did this condition begin?**		
Has it occurred before? YES	NO	**Has the condition:** Worsened	Stayed the same	Comes and goes	
On a scale of 1-10, 10 being the worst, rate your condition:		**Does this condition interfere with:** Sleep	Work	Daily Activities	
Is condition: Job related	Auto Related	Home Injury	Fall	Other(Explain)	
Date of Accident:	**Time of Accident:**		**Are you, or do you think you are pregnant?** YES	NO	
Do most of your current & past health issues occur on one side of your body?		Right side	Left side	Both	
Drugs you now take: Tranquilizers	Pain killers/Muscle Relaxation	Blood Pressure Med			
Insulin	Antidepressants	Others			
Others doctors seen for this condition: YES	NO	OTHER			
Do you suffer from any condition other than that for which you are now consulting us for?					

CURRENT HEALTH HABITS

Do you smoke:	YES	NO	**Do you have regular dentist check-ups:**	YES	NO
Do you drink:	YES	NO	**Do you exercise regularly:**	YES	NO
Do you drink bottled water:	YES	NO	**Do you belong to a gym/sports club:**	YES	NO
Sleeping Posture: SIDE	STOMACH	BACK	RESTLESS		
Rate your stress level on a scale of 1-10, (10 being the worst):					

PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations:	Appendix Back Surgery Other(Describe)	Tonsils Broken Bones	Gall Bladder Back Surgery	Hernia
Major Accidents or Falls:				
Hospitalization (other than above):				
Previous Chiropractic Care: YES NO	**Dr.'s name and approx. date of last visit:**			

HEALTH PROBLEMS

Check all that apply:

Severe or Frequent Headaches	**Sinus Problems/Asthma**	**Dizziness**
Loss of Sleep	**Congenital Heart Defect**	**Shingles**
Pain Between Shoulders	**Heart Murmur**	**Hepatitis**
Frequent Neck Pain	**High/Low Blood Pressure**	**Cancer**
Numbness or Pain in Arms/Legs	**Difficulty Breathing**	**Anemia**
Lower Back Problems	**Arthritis**	**HIV/AIDS**
Digestive Problems	**Pinched Nerve(s)**	**Tuberculosis**
Ulcers/Colitis	**Diabetes**	**Osteoporosis**
Heart Attack/Stroke	**ADD/ADHA/Autism**	**Thyroid High Low**

What most important to you?

1. **Temporary Relief** of **pain** or **discomfort**; this phase **enables a person to heal**.

   Acute/Intensive Care

2. Working on resolving the **cause of the problem**, as well as the **effect (symptoms)**. This phase is where healing occurs.

   Correction Care

3. **Explore** and **improve** your **abilities** and **build health and wellness**.

   Wellness Care

If you would like the doctor to suggest the type of care appropriate for you.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient Signature _____ Date _____

Parent/Guardian Signature Authorizing Care _____ Date_____