

Joga Chiropractic Center

Patient Name _____ Birthdate _____ Sex M / F
 Address _____ City _____
 State _____ Zip _____ Telephone (____) _____ Patient Primary Language _____
 Occupation _____ Employer _____ Work Phone _____
 Address _____ City _____ State _____ Zip _____
 Subscriber Name _____ Health Plan: _____
 Subscriber ID # _____ Group # _____ Spouse Name _____
 Spouse Employer _____ City _____ State _____ Zip _____
 Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

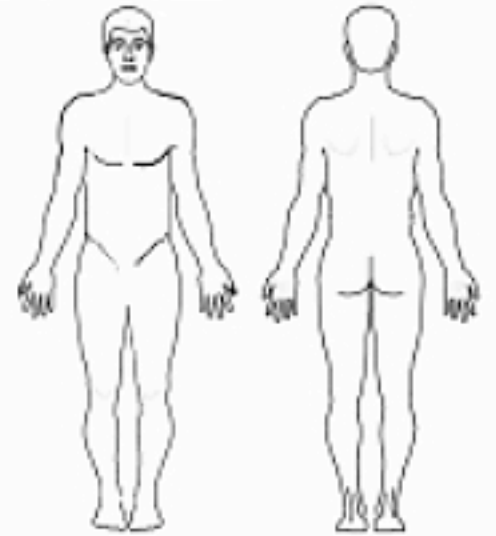
Headache Neck Pain Mid-back Pain Low Back Pain

Other _____

Is this? Work Related Auto Related N/A

Date Problem Began: _____

How Problem Began: _____



Current complaint (how you feel today):

0	1	2	3	4	5	6	7	8	9	10	
No Pain											Unbearable Pain

How often are your symptoms present?
 (Intermittent) 0 – 25% 26 – 50% 51 – 75% 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken: _____ What areas were taken? _____

Please check all of the following that apply to you:

- | | |
|--|--|
| <input type="checkbox"/> Recent Fever
<input type="checkbox"/> Diabetes
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Stroke (date) _____
<input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.)
<input type="checkbox"/> Taking Birth Control Pills
<input type="checkbox"/> Dizziness/Fainting
<input type="checkbox"/> Numbness in Groin/Buttocks
<input type="checkbox"/> Cancer/Tumor (explain) _____

<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Other Health Problems (explain) _____

_____ | <input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Currently Pregnant, # weeks _____
<input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss
<input type="checkbox"/> Marked Morning Pain/Stiffness
<input type="checkbox"/> Pain Unrelieved by Position or Rest
<input type="checkbox"/> Pain at Night
<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/> Surgeries _____

<input type="checkbox"/> Medications _____

_____ |
|--|--|

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature _____ Date _____