# Conejo Chiropractic Relief Center

## David Biedebach, D.C., C.C.F.C.

Name _____ Address _____

City _____ State ____ Zip Code _____ Home Phn _____ Cell Phn _____

E-mail: _____ SSN _____

Date of Birth _____ Age _____ Height _____ Weight _____

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ # of Children _____ Name of Spouse (or Parent) _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip Code _____

Work Phn _____ Email: _____

What is the name of your family physician? _____ What city are they located in? _____

Have you ever been to a Chiropractic doctor? ____ If yes, doctor's name: _____ Date of last visit: _____

What problems (health or bodily pains) are you experiencing, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. _____ For how long? _____
2. _____ For how Long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

Are there any other activities, incidents, or events that may have caused these complaints? ____ If yes, please explain:

_____

Currently or in the past have you ever experienced any of these complaints while working? _____ If yes, please describe what activities may be causing you to experience these complaints while working: _____

Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of injury? _____

Do you have an attorney for this work injury? __Yes __No If yes, who is your attorney? _____

Have you been involved in a car accident in the last 12 months? __Yes __No If yes, what is the date of the accident? _____

Do you have an attorney for this car accident? __Yes __No If yes, who is your attorney? _____

Have you ever had any surgeries or hospitalizations? ____ If yes, please list: _____

Please list any current or past injuries and illnesses not listed above: _____

Please list all medications (prescription or non-prescription) you are currently taking: ☐ Asprin/Tylenol/Ibuprofen ☐ Pain Killers ☐ Muscle Relaxers ☐ Insulin ☐ Tranquilizers ☐ Birth Control Pills ☐ Others

_____

For each of the six categories of daily living listed, **PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF PAIN WHILE DOING THE FOLLOWING ACTIVITES.**
Zero (0) means no disability at all, and a score of ten (10) means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing.

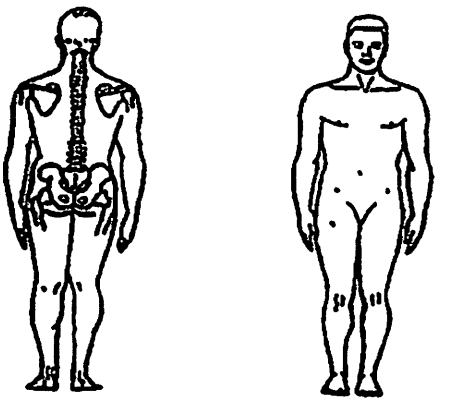
0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

1. **FAMILY/HOME RESPONSIBILITIES: activities related to the home of family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.)** _____
2. **RECREATION: hobbies, sports, and other similar leisure time activities.** _____
3. **SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions.** _____
4. **OCCUPATION: activities that are a part of or directly related to one's job including nonpaying Jobs as well, such as that of a homemaker or volunteer worker.** _____
5. **SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)** _____
6. **LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing.** _____

**Please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.**

COMPLETE THESE DIAGRAMS



**Method of payment for today's charges:** ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD** ☐ _____

**NOTICE - NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:**

1. **All first visit charges are payable when services are rendered.**
2. **The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.**

**Patient's Signature** _____ **Date** _____