Conejo Chiropractic Relief Center

David L. Biedebach, D.C., C.C.F.C.

Name:			**Address:**				
City:		**State:**	**Zip:**		**Home Ph:**	**Cell Ph:**	
Email:			**SSN:**				
DOB:		**Age:**	**Height:**		**Weight:**		
Male		**Female**	**Single**	**Married**	**Divorced**	**# of Children:**	
					Name of Spouse (or Parent):		
Employer:					**Occupation:**		
Address:			**City:**		**State:**	**Zip:**	
Work Ph:			**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, Dr'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. Low Back Pain — **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 cause 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, date of injury?** _____

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

Have you been involved in a car accident in the last 12 months? _____ **If yes, date of accident?** _____

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

Do you have an attorney for this accident?

Have you ever had any surgeries or hospitalizations? _____ **If yes, please list (below):**

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

Please list all medications (prescription or non-prescription) you are currently taking:

Acetaminophen / Aspirin / Ibuprofen: ☐ **Pain Killers:** ☐ **Muscle Relaxers:** ☐ **Insulin:** ☐ **Tranquilizers:** ☐
Birth Control Pills: ☐ **Others:**

Conejo Chiropractic Relief Center

David L. Biedebach, D.C., C.C.F.C.

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 ACTIVITIES:**

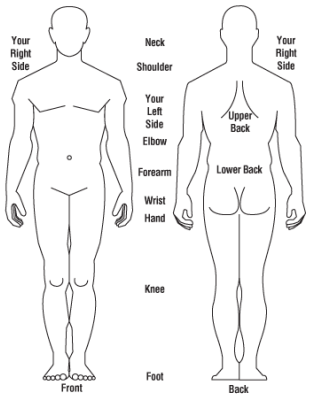
Zero (0) means no disability at all, and a score of ten (10) means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

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 or 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 ACITIVITY:** 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 domestic or volunteer work.	
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 of 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**	☐	**OTHER:**

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 visits 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 if the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature _____ Date _____