R. J. Ammon Chiropractic
4200 East Ave. Suite #102 Livermore, CA 94550 Phone: (925) 371-7300

Initial Health Status

Patient Name: _____ Birth date: ____/____/____ Age: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

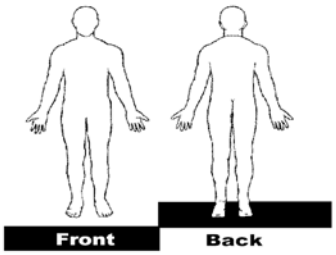
Occupation: _____ Employer: _____ Work Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Marital Status: S M D W Spouse: _____

Social Security #: _____ Driver's License #: _____ Referred By: _____

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



Describe your current problem and how it began:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Arm pain ☐ Shoulder pain
☐ Hand pain ☐ Low back pain ☐ Leg pain ☐ Foot pain ☐ Other: _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date problem began; _____

How problem began; _____

_____

In general would you say your overall health right now is;

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

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

0 1 2 3 4 5 6 7 8 9 10

No interference **Unable to carry on any activities**

How do you feel today? (Mark an X on the line)

Best ◄——————————► Worst

Pain Scale

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable Pain**

On a daily basis, how often are your symptoms present?

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 6-100%

Can you perform your daily activities? ☐ Yes ☐ No If no, please describe: _____

Have you seen another: M.D. _____ D.C. _____ Other: _____

Have you had: ☐ X-Rays ☐ MRI ☐ CT Scan Date Of: _____ Where: _____

What areas were taken? _____

Please check all of the following that apply to you: ☐ **None apply**

No	Yes	Condition	No	Yes	Condition
__	__	History of recent infection	__	__	Prostate problems
__	__	Recent fever	__	__	Frequent urination
__	__	HIV/AIDS	__	__	Pregnancy/ # of births: _____
__	__	Diabetes	__	__	Abnormal weight ☐gain ☐loss
__	__	Corticosteroid use	__	__	Epilepsy / Seizures
__	__	Recent trauma	__	__	Cancer/Tumor; type: _____
__	__	Birth control pills	__	__	Marked morning pain/stiffness
__	__	Menstrual problems	__	__	Pain at night
__	__	Visual disturbances	__	__	Pain unrelieved by position or rest
__	__	High blood pressure	__	__	History of low/mid back pain
__	__	Stroke / Date: _____	__	__	History of neck pain
__	__	Dizziness/Fainting	__	__	History of headaches or migraines
__	__	Numbness in groin/buttocks	__	__	Arthritis
__	__	Urinary retention	__	__	History of alcohol use
__	__	Bowel /Bladder problems	__	__	History of tobacco use
__	__	Osteoporosis/osteopenia	__	__	Other health problems (explain) _____
__	__	Aortic aneurysm	_____		

Family History:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular problems/Strokes ☐ Rheumatoid Arthritis

Please list/provide your past surgeries:

_____

_____

Please list/provide your current medications:

_____

_____

- I agree to pay in full for all services rendered at the time of visit, unless other arrangements have been made and agreed to. If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for the legal fees, collection agency fees, and any other expenses incurred in collecting my account balance.
- I authorize the staff to perform any necessary services needed during treatment.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand that I am liable for all charges for services rendered.
- I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.
- We reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.
- **The missed appointment fee is $20.00.**

_____	_____	_____
Print Patient Name	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date