COSTA
LIFESTYLE MEDICINE

Personal Information (Confidential) **Today's Date_____**

Name_____Address_____
City _____ State_____ Zip_____
Email_____Home #_____Cell #_____
Fax #_____Work_____
Social Security #_____ Birth date _____ Height _____Weight_____
Age_____ Drivers License # _____

Occupation_____Employer_____
Address_____ City_____ State___ Zip_____

Single _____Married_____Divorced_____ Widowed_____ Separated_____# of children_____
Spouse's Name _____or Legal Guardian_____
Address_____City_____State_____Zip_____
Spouse Occupation _____Cell#_____
Home#_____Spouses Employer City_____ State_____

Emergency Contact_____ Phone #_____

Responsible Party (if other than yourself)
Name _____SSN#_____
Home # _____Relationship to Patient_____
Address_____ City_____ State_____
Method of payment: Cash_____Insurance_____ Worker's Comp_____ Med Pay_____

Insurance Information
Name of Insured _____Birthday_____
Medical Insurance Company_____Policy # Group #_____
Insurance Co. Phone _____
Address_____
Is Chiropractic treatment covered on your plan? Yes _____No_____
Do you have additional insurance? Yes_____ No_____

Referred By: _____

Hobbies and Recreational Sports_____

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times/wk and duration_____

MEDICAL HISTORY

PLEASE FILL IN THE ANSWER OR CIRCLE ANSWER WHEN APPRORIATE. Patient Name _____

1. Previously treated by which doctors: D.C._____M.D._____

2. Have you ever received Chiropractic Care? Yes_____No _____ If yes, when?_____

3. Primary reasons for seeking chiropractic care:

   Primary reason: _____

   Secondary reason: _____

   Location of Primary Complaint:_____

   Primary Complaint Began when and how? _____

   Date problem began? _____

   Other factors contributing to the primary and secondary reasons: _____

4. Please circle the Quality of the complaint/pain:

   Dull Aching Sharp Shooting Burning Throbbing Deep Nagging Other _____

   Please rate your pain on a scale of 1 to 10 (o = no pain and 10 = excruciating pain) 1 2 3 4 5 6 7 8 9 10

5. Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____
6. Do you have any numbness or tingling in your body? Where? _____
7. How did this problem begin (falling, lifting, etc.)? _____
8. How is your condition changing? Getting Better Getting Worse Not Changing
9. Have you had this condition in the past? YES NO
10. How often do you experience your symptoms?

    Constantly (76-100% of the day) _____ Frequently (51-75% of the day) _____

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Occasionally (26-50% of the day) _____ Intermittently (0-25% of the day) _____

PLEASE FILL IN THE ANSWER OR CIRCLE ANSWER WHEN APPRORIATE. Patient Name_____

11. Describe the nature of your symptoms: Please circle:

Sharp Dull Numb Burning Shooting Tingling Radiating Pain Tightness Stabbing Throbbing

12. Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain) 1 2 3 4 5 6 7 8 9 10

13. How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

14. What activities does it affect? _____

15. What time of day is your pain better? Morning Afternoon Evening

16. Does your pain increase when you sneeze, cough or have a bowel movement? _____

17. Describe any bowel or bladder changes. _____

18. List emotional/stress related problems. _____

19. Please make X's where you are experiencing pain?

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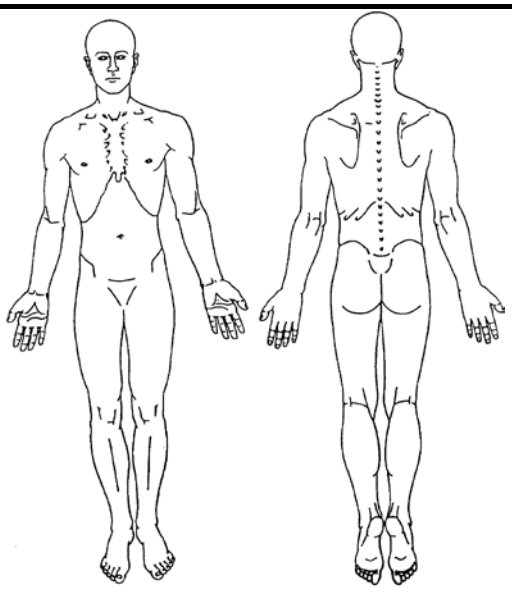

PLEASE FILL IN THE ANSWER OR CIRCLE ANSWER WHEN APPRORIATE. Patient Name _____

20. Date of last physical examination: _____ Any positive finding? _____

Do you smoke? Yes No

21. Do you drink alcohol? Yes No How many per day? _____

22. Do you drink caffeine? Yes No How many per day? _____

23. Do you exercise? Yes No What forms and how often? _____

24. Have you seen any other medical care provider? No Yes Who? _____

25. Were x-rays taken? Yes No Where? _____

26. Allergies _____

27. Medications:_____ Reason for taking_____
Medications _____Reason for taking_____
Medications _____Reason for taking_____

28. What vitamins, supplements, minerals or herbs are you taking?

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_____

_____

29. Surgeries:

Date _____ Type of Surgery _____

Date _____ Type of Surgery _____

Date _____ Type of Surgery _____

Date _____ Type of Surgery _____

30. List any significant injuries, fractures, hospitalizations, major dental work and medical conditions.

Issue	When	Length of Treatment	By Whom	Treatment

PLEASE FILL IN THE ANSWER OR CIRCLE ANSWER WHEN APPRORIATE. Patient Name_____

31. **Females/ Pregnancies and outcomes: (Outcome = Natural Birth. C-Section, Breach, Miscarriage, etc)**

Pregnancy/Date of Delivery 1. _____ Outcome _____

Pregnancy/Date of Delivery 2. _____Outcome_____

Pregnancy /Date of Delivery 3._____ Outcome_____

What was the date of the beginning of your last menstrual period? _____

32. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death_____Age at death _____

Cause of parents or siblings death_____Age at death _____

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Cause of parents or siblings death_____Age at death _____

33. Do you feel your health is affecting your lifestyle?

[ ] Interrupted sleep
[ ] Moody
[ ] Uncomfortable/Nervousness
[ ] Hinders recreational activities
[ ] Trouble falling asleep
[ ] Irritable
[ ] Anxiety

34. Please list your Health Goals in **Priority order:**

1._____

2. _____

3. _____

4. _____

Please put a check mark (√) or (X) in correct column. Patient Name_____

Family History: Please put a check mark (√) or (X) in correct column. **Y = You** **F= Family**

	Y	F		Y	F		Y	F		Y	F
Allergy			Epilepsy			Measles			Spinal Disorders		
Anemia			Gout			Mumps			Thyroid		
Arthritis			Heart Disease			Polio			Tonsillitis		
Asthma			Influenza			Pleurisy			Tuberculosis		
Cancer			Kidney Disease			Pneumonia			Whooping Cough		
Diabetes			Lung Disease			Rheumatic Fever					
Eczema			Mental Illness								.

Review of Systems: Check below if you have had any of the following.

Check **P-Prior** or **C- Current** (in the last few months) and S-**Severity** (rate on a scale of 1-10)

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SKIN	P	C	S	WOMEN ONLY	P	C	S	HABITS/	P	C	FREQUENCY/
								EXERCISE			AMOUNT of TIME
Skin Eruptions				Painful Periods				Smoking			
Itching				Excessive Flow				Alcohol			
Bruising Easily				Irregular Cycles				Coffee			
Dryness				Hot Flashes				Chocolate			
Boils				Cramps/Backache				Drugs			
Sensitive Skin				Vaginal Discharge				Stretching/Yoga			
Hives				Last Pap Smear date				Lifts Weights			
Acne				Other				Cardio Exercise			
Other_____								Prayer/Meditation			.

Muscles/Joints	P	C	S		P	C	S		P	C	S
Low Back Pain/Stiffness				Wrist/Hand Pain				Spinal Curvature			
Weakness				Foot/Ankle Pain				Shoulder Pain			
Hip Pain				Tail Bone Pain				Mid back Pain			
Neck Pain/ Stiffness				Knee Pain Left				Elbow Pain Left			
Swollen Joints				Knee Pain Right				Elbow Pain Right			

Review of Systems: Check below if you have had any of the following.

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General Symptoms	P	C	S		P	C	S		P	C	S
Headaches				Cold Sweats				Loss of Balance			
Fever				Wheezing				Loss of Memory			
Chills				Numb/tingling/cold in arms				Loss of Sleep			
Night Sweats				Numb/tingling/cold in legs				Loss of Smell			
Fainting				Numb/tingling/cold in hands				Confusion			
Dizziness				Numb/tingling/cold in feet				Depression			
Convulsions				Numb/tingling/cold in head				Twitching			
Shortness of Breath				Numb/tingling/cold in toes				Tremors			
Fatigue				Loss of Taste				Allergies			
Facial Pain											
Gastro-Intestinal	**P**	**C**	**S**		**P**	**C**	**S**		**P**	**C**	**S**
Poor Appetite				Diarhhea				Heart Burn			
Poor Digestion				Colon Trouble				Colititis			
Excessive Hunger				Hemorrhoids				Hernis			
Difficult Chewing				Liver Problems				Bloody Stool			
Frequent Nausea				Jaundice				Balck Stool			
Vomiting				Gall Bladder Trouble				Belching/Gas			
Vomiting Blood				Excessive Thirst				Persistent Cough			
Pain Over Stomach				Weight Loss/ Gain				Coughing Phlegm			
Constipation				Abdominal Cramps				Coughing Blood			
E E N T	**P**	**C**	**S**		**P**	**C**	**S**		**P**	**C**	**S**
Vision Problems				Nasal Obstruction				Enlarged Thyroid			
Crossed Eyes				Nose Bleeds				Speech Difficulty			
Pain in/behind Eyes				Sore Throat				Sinus Trouble			
Deafness				Hoarseness				Dental Problems			
Hearing Loss				Hay Fever				Stuffy Nose			
Ear Discharge				Sore Mouth or Gums				TMJ/Jaw/Clicking			
Ear Infections/aches				Frequent Colds				Ringing/Buzzing			

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Genito Urinary	**P**	**C**	**S**		**P**	**C**	**S**		**P**	**C**	**S**
Frequent Urination				Bed Wetting				Painful Urination			
Blood in Urine				Prostrate Trouble				Unable to Control Urine			
Kidney Infection											

Cardio-Vascular	**P**	**C**	**S**		**P**	**C**	**S**		**P**	**C**	**S**
Rapid Heart Beat				Shortness of Breath				Ankle Swelling			
Slow Heart Beat				Lung Problems				Light Headedness			
Irregular Heart				High Blood Pressure				Strokes			
Heart Problems				Low Blood Pressure				Poor Circulation			
Chest Pain				Varicose Veins							

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient Signature_____Date _____

Parent or Legal Guardian Signature_____ Date_____

Doctors Signature _____Date_____

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