Welcome to DeForest Chiropractic Clinic

815 E. Latham Ave · Hemet · Ca · 92543 · (951) 925-2400

We are pleased to welcome you to our practice. Please take a few minutes to fill out our forms as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name: _____
Last First Initial

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

SS#: _____ Drivers License#: _____ Phone #: _____ Cell#: _____

Sex: L Male L Female Date of Birth: _____ Age: ____ Primary Physician: _____

L Single L Married L Widowed L Separated L Divorced Spouse's Name: _____

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone #: _____

Whom may we thank for referring you?: _____

Notify in case of emergency: _____ Phone #: _____ Work Phone #: _____

Insurance Information

Person Responsible for this Account: _____
Last First Initial

Relationship to Patient: _____ Date of Birth: _____ SS#: _____

Insurance Co.: _____ Id#: _____ Group #: _____

Reason For Visit

Describe your current Problem: L Headache L Neck Pain L Mid-Back Pain L Low-Back Pain L Other _____

Is This? L Work Related L Auto Related L N/A Date Problem Began: _____

How Problem Began: _____

What makes your pain better? _____

How many days a week do you have this pain? _____ Is this condition getting worse? L Yes L No

How often are your symptoms present? (intermittent) L 0-25% L 26-50% L 51-75% L 76-100% (Constant)

Current Complaint (How you feel today): L_____

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

Have you ever seen a chiropractor? L Yes L No If yes, Why? _____

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

L_____

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

Condition interfering with: L Work L Sleep L Daily Routine L Recreation L Other _____

Activities or movements that are difficult/painful to perform: L Sitting L Walking L Bending L Lying down L Lifting

Type of Pain: L Sharp L Dull L Throbbing L Aching L Burning L Tingling L Numbness L Cramping L Sitting L Swelling L Other _____

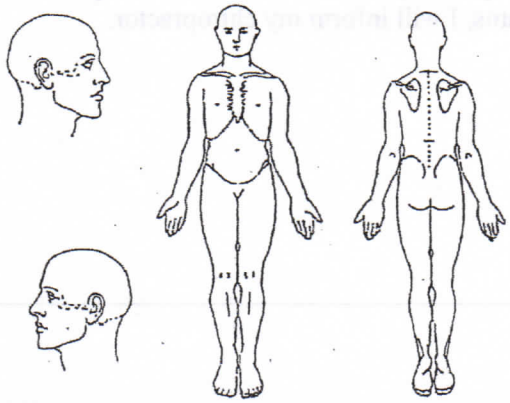
Have you been treated by a medical physician for this condition? _____

If so, when and where?: _____

Have you had Spinal X-Rays, MRI, CT Scan? L Yes L No Facility Name: _____

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

Please Mark and X where you have pain or other symptoms



(Please Complete Both Sides)