# 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: ☐Male ☐Female Date of Birth: _____ Age: ____ Primary Physician: _____

☐Single ☐Married ☐Widowed ☐Separated ☐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: ☐Headache ☐Neck Pain ☐Mid-Back Pain ☐Low-Back Pain ☐Other _____

Is This? ☐Work Related ☐Auto Related ☐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? ☐Yes ☐No

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

Current Complaint (How you feel today): _____

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

Have you ever seen a chiropractor? ☐Yes ☐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)

_____

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

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

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

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

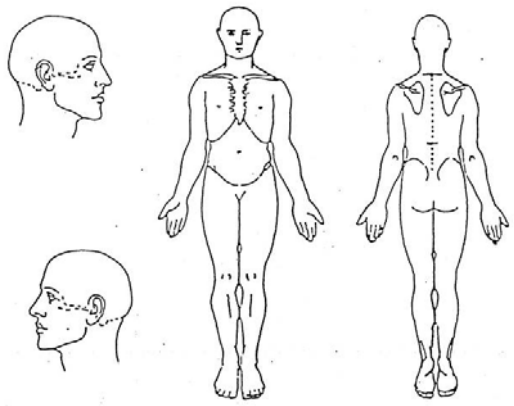
Have you been treated by a medical physician for this condition? _____

If so, when and where?: _____

Have you had Spinal X-Rays, MRI, CT Scan? ☐Yes ☐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)**

## Please list any serious injuries or surgeries you have had in your lifetime:

| | Description | Date |
|---|---|---|
| Falls | _____ | _____ |
| Head Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Dislocations | _____ | _____ |
| Surgeries | _____ | _____ |
| Other Serious Injuries | _____ | _____ |

Women: Are you Pregnant? ☐Yes ☐No If so, How far along? _____ Nursing? ☐Yes ☐No

## Have you had any of the following conditions?

| | | | |
|---|---|---|---|
| ☐Heart Attack/ Stroke | ☐Arthritis | ☐Ringing in Ears Ulcer/Colitis | ☐High Blood Pressure |
| ☐Congenital Heart Defect | ☐Frequent Neck Pain | ☐Sever/Frequent Headaches | ☐Gout |
| ☐Alcohol/Drug Abuse | ☐Jaw Pain | ☐Diabetes/Tuberculosis | ☐Numbness, where? |
| ☐Shingles | ☐Corticosteroid Use | ☐Recent Fever | _____ |
| ☐Osteoporosis | (cortisone, prednisone, etc.) | ☐Prostate Problems | _____ |
| ☐Menstrual Problems | ☐Urinary Problems | ☐Abnormal Weight ☐Gain ☐Loss | ☐Marked Morning |
| ☐Pain Unrelieved by Position or Rest | ☐Pain at Night | ☐Visual Disturbances | Pain/ Stiffness |
| ☐Fainting/Seizures/Epilepsy | ☐Wrist Pain | ☐Dizziness | ☐Shoulder Pain |
| ☐Emphysema/Glaucoma | ☐Psychiatric Problems | ☐Arm Pain | ☐Tingling, where? |
| ☐Kidney Problems | ☐Difficulty Breathing | ☐Leg Pain | _____ |
| ☐Artificial Bones/Joints | ☐Hepatitis | ☐ Lower Back Problems | _____ |
| ☐Cancer | ☐Anemia | ☐Sever/Frequent Earaches | ☐HIV Positive/AIDS |
| ☐Other _____ | | ☐Muscle Spasms, Where? _____ | |
| _____ | | _____ | |

Medications/ Nutrition: _____

_____

_____

## Personal Habits:

| | Heavy | Moderate | Light | None |
|---|---|---|---|---|
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Coffee | ☐ | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Drugs | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ |
| Appetite | ☐ | ☐ | ☐ | ☐ |

## Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor, Dr. Lisa DeForest, to help determine appropriate chiropractic treatment. If there is any change in my medical status, I will inform my chiropractor.

Signature: _____ Date: _____