

1 GENERAL INFORMATION

HOW DID YOU HEAR ABOUT **NAKANO CHIROPRACTIC**? _____
 NAME : _____ TODAY'S DATE: ____ / ____ / ____
 DATE OF BIRTH (MM/DD/YYYY) : _____ SEX: F M DRIVER'S LICENSE NO#: _____
 SOCIAL SECURITY #: _____ EMAIL : _____
 ADDRESS : _____
 PHONE : _____
 INSURED'S NAME (if different from patients): _____ RELATIONSHIP TO PATIENT: _____
 INSURANCE POLICY#: _____ ARE YOU COVERED BY ADDITIONAL INSURANCE? Y N

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE WITH _____
 AND ASSIGN DIRECTLY TO NAKANO CHIROPRACTIC ALL INSURANCE BENEFITS, IF ANY. I HEREBY AUTHORIZE
 THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE
 THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE: _____

MARRIAGE STATUS : SINGLE MARRIED WIDOW DIVORCED SEPERATED

OF SIBLINGS: _____

SPOUSE NAME : _____ # OF CHILDREN : _____

PATIENT OCCUPATION (NAME OF BUSINESS): _____

WORK ADDRESS : _____

WORK PHONE : _____

FAMILY PHYSICIAN : _____ PHONE : _____

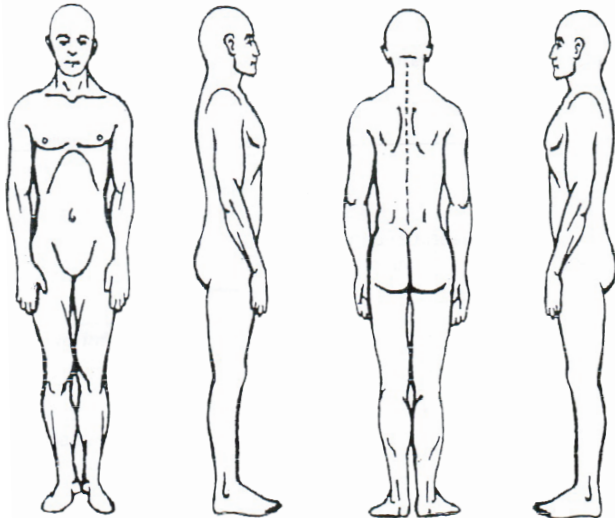
EMERGENCY CONTACT: _____ RELATIONSHIP : _____

EMERGENCY PHONE : _____

ARE YOU CURRENTLY PREGNANT? Y / N DUE DATE (MM/DD/YYYY) : _____

2 CURRENT HEALTH CONDITION

PLEASE MARK WHERE YOU ARE CURRENTLY EXPERIENCING SYMPTOMS :



- | | |
|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> SHARP PAIN | <input type="checkbox"/> TINGLING |
| <input type="checkbox"/> TIGHTNESS | <input type="checkbox"/> DULLNESS |
| <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> DISTORTION |
| <input type="checkbox"/> OTHER _____ | |
| _____ | |
| _____ | |

WHEN DID THE SYMPTOMS START? _____

PLEASE DESCRIBE, IF KNOWN, HOW THE PAIN MAY HAVE STARTED. _____

HAVE YOU EXPERIENCED THE SYMPTOMS BEFORE? Y / N

IS YOUR CONDITION DUE TO AN ACCIDENT? Y / N

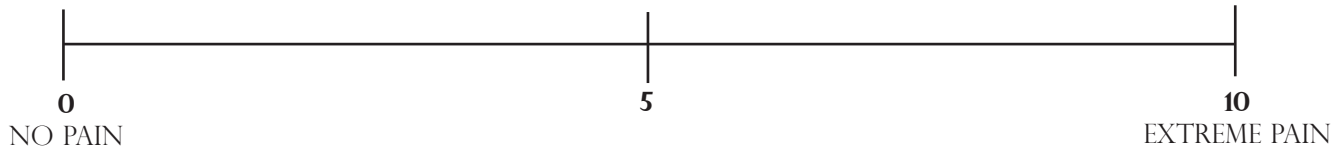
IF YES, PLEASE DESCRIBE THE TYPE OF ACCIDENT : _____

ARE YOUR SYMPTOMS : INCREASING DECREASING THE SAME

ON AVERAGE, HOW MANY HOURS DO YOU SLEEP? _____ HOURS

DO YOUR SYMPTOMS DISTURB YOUR SLEEP? Y / N

PLEASE RATE THE LEVEL OF PAIN YOU ARE EXPERIENCING CURRENTLY ON A SCALE OF 0 - 10.



HOW MANY DAYS A WEEK DO YOU EXPERIENCE PAIN? 1 2 3 4 5 6 7

DOES THE PAIN TRAVEL TO OTHER PARTS OF YOUR BODY? IF YES, PLEASE DESCRIBE.

3 _____

EXERCISE AND DIET

HOW MANY TIMES A WEEK DO YOU EXERCISE? ___ PER/WEEK

ARE YOU CURRENTLY ON A SPECIAL DIET PLAN? _____

DO YOU CONSUME ALCOHOL? ___ TIMES /WEEK ___ GLASSES /TIME

DO YOU CONSUME CAFFEINE? ___ CUPS/DAY DO YOU SMOKE? ___ CIGARETTES/DAY

ARE YOU CURRENTLY UNDER A LOT OF STRESS? Y / N

IF YES, PLEASE EXPLAIN : _____

WHAT MAKES THE CONDITION BETTER?

SLEEPING REST WALKING STANDING SITTING EXERCISE HEAT ICE

WHAT MAKES CONDITION WORSE?

SLEEPING REST WALKING STANDING SITTING EXERCISE HEAT ICE
 LIFTING SNEEZING COUGHING BENDING

4 MEDICAL HISTORY

PLEASE MARK THE FOR ANY CONDITIONS YOU **CURRENTLY** HAVE &
 FOR ANY CONDITIONS YOU **PREVIOUSLY** HAVE HAD

MUSCULOSKELETAL:

HEADACHES NECK PAIN TINGLING IN HANDS
 LOW BACK PAIN UPPER BACK PAIN TINGLING IN FEET
 LOWER EXTREMITY PAIN TIGHTNESS IN UPPER BACK DIZZINESS

GENERAL:

ALCOHOLISM THYROID RHEUMATOID ARTHRITIS TUBERCULOSIS
 CANCER OSTEOARTHRITIS DEPRESSION VENEREAL DISEASE (STD)

HEMATOLOGIC/LYMPHATIC:

ANEMIA GOUT HIGH CHOLESTEROL DIABETES

PLEASE MARK THE FOR ANY CONDITIONS YOU CURRENTLY HAVE &
 FOR ANY CONDITIONS YOU PREVIOUSLY HAVE HAD

RESISTANCE TO INFECTION:

- CATCH COLDS EASILY FREQUENT SINUS TROUBLE FREQUENT INFLUENZA

GASTROINTESTINAL:

- | | | |
|---|---|---|
| <input type="checkbox"/> <input type="radio"/> GALL BLADDER PROBLEMS | <input type="checkbox"/> <input type="radio"/> NAUSEA | <input type="checkbox"/> <input type="radio"/> VOMITING |
| <input type="checkbox"/> <input type="radio"/> LIVER TROUBLE/ HEPATITIS | <input type="checkbox"/> <input type="radio"/> DIARRHEA | <input type="checkbox"/> <input type="radio"/> CONSTIPATION |
| <input type="checkbox"/> <input type="radio"/> EXCESSIVE THIRST | <input type="checkbox"/> <input type="radio"/> BLOOD IN STOOL | <input type="checkbox"/> <input type="radio"/> RECENT WEIGHT GAIN |
| <input type="checkbox"/> <input type="radio"/> PAIN OVER STOMACH | <input type="checkbox"/> <input type="radio"/> COLITIS | <input type="checkbox"/> <input type="radio"/> RECENT WEIGHT LOSS |
| <input type="checkbox"/> <input type="radio"/> HEARTBURN | <input type="checkbox"/> <input type="radio"/> HIATAL HERNIA | |

CARDIOVASCULAR:

- | | | |
|---|--|--|
| <input type="checkbox"/> <input type="radio"/> PAIN OVER HEART | <input type="checkbox"/> <input type="radio"/> PRESSURE OVER CHEST | <input type="checkbox"/> <input type="radio"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> <input type="radio"/> SWELLING IN ANKLES | <input type="checkbox"/> <input type="radio"/> HEART ATTACK | <input type="checkbox"/> <input type="radio"/> SHORTNESS OF BREATH ON EXERTION |
| <input type="checkbox"/> <input type="radio"/> LOW BLOOD PRESSURE | <input type="checkbox"/> <input type="radio"/> STROKE | |

NERVOUS SYSTEM:

- | | |
|---|--|
| <input type="checkbox"/> <input type="radio"/> DIZZINESS/ LIGHTHEADED | <input type="checkbox"/> <input type="radio"/> DISCOORDINATION |
| <input type="checkbox"/> <input type="radio"/> FAINTING | <input type="checkbox"/> <input type="radio"/> MEMORY LOSS |

URINARY TRACT:

- | | | |
|---|--|--|
| <input type="checkbox"/> <input type="radio"/> BLOOD IN URINE | <input type="checkbox"/> <input type="radio"/> PAINFUL URINATION | <input type="checkbox"/> <input type="radio"/> KIDNEY STONES |
| <input type="checkbox"/> <input type="radio"/> INABILITY TO CONTROL URINE | <input type="checkbox"/> <input type="radio"/> BLADDER INFECTION | |

EYE, EAR, NOSE, AND THROAT:

- | | | |
|--|---|--|
| <input type="checkbox"/> <input type="radio"/> VISION PROBLEMS | <input type="checkbox"/> <input type="radio"/> DIFFICULT SPEECH | <input type="checkbox"/> <input type="radio"/> DIFFICULTY BREATHING THROUGH NOSE |
| <input type="checkbox"/> <input type="radio"/> EAR PAIN | <input type="checkbox"/> <input type="radio"/> HEARING LOSS | <input type="checkbox"/> <input type="radio"/> SORE THROAT |
| <input type="checkbox"/> <input type="radio"/> LOSS IN VISION | <input type="checkbox"/> <input type="radio"/> EAR NOISES | |
| <input type="checkbox"/> <input type="radio"/> NOSE BLEEDS | <input type="checkbox"/> <input type="radio"/> DENTAL PROBLEMS | |

RESPIRATORY:

- | | | |
|--|---|--|
| <input type="checkbox"/> <input type="radio"/> COUGHING UP BLOOD | <input type="checkbox"/> <input type="radio"/> SPITTING UP PHLEGM | <input type="checkbox"/> <input type="radio"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> <input type="radio"/> ALLERGIES | <input type="checkbox"/> <input type="radio"/> ASTHMA | <input type="checkbox"/> <input type="radio"/> CHONIC COUGH |
| | | <input type="checkbox"/> <input type="radio"/> EMPHYSEMA |

WOMEN ONLY:

- | | |
|--|--|
| <input type="checkbox"/> <input type="radio"/> IRREGULAR PERIODS | <input type="checkbox"/> <input type="radio"/> HEADACHES WITH PERIOD |
| <input type="checkbox"/> <input type="radio"/> MENOPAUSAL SYMPTOMS | <input type="checkbox"/> <input type="radio"/> HYSTERECTOMY |

MEN ONLY:

- | | |
|---|---|
| <input type="checkbox"/> <input type="radio"/> BURNING ON URINATION | <input type="checkbox"/> <input type="radio"/> DRIPPING AFTER URINATION |
| <input type="checkbox"/> <input type="radio"/> PROSTATE TROUBLE | <input type="checkbox"/> <input type="radio"/> NEED TO GET UP AT NIGHT TO URINATE |
| <input type="checkbox"/> <input type="radio"/> FEELING OF INCOMPLETE BOWEL EVACUATION | <input type="checkbox"/> <input type="radio"/> DIFFICULTY STARTING URINE |

PLEASE CIRCLE IF ANY OF THE FOLLOWING BEEN PRESENT AMONG FAMILY MEMBERS.

HIGH BLOOD PRESSURE STROKE DIABETES CANCER ARTHRITIS DEPRESSION

HAVE YOU EVER RECEIVED CHIROPRACTIC TREATMENT? Y / N

IF YES, WHAT WAS THE NAME OF THE CHIROPRACTIC CLINIC? _____

HAVE YOU EVER RECEIVED TREATMENT FOR THE CURRENT SYMPTOM AT ANY OTHER FACILITY?

IF YES, PLEASE WRITE THE NAME OF THE FACILITY _____



PLEASE CIRCLE THE TYPE OF TREATMENT RECIEVED FOR THE CURRENT SYMPTOM.

| | | | | | |
|--------------|-----------|---------|----------------|---------|----------------------|
| MEDICATION | INJECTION | SURGERY | CHIROPRACTIC | MASSAGE | PHYSICAL THERAPY |
| ACCUPUNCTURE | HEAT | ICE | EMS ULTRASOUND | LASER | SPINAL DECOMPRESSION |

PLEASE DESCRIBE AND LIST THE DATE OF ANY INJURIES/ SURGERIES.

WHAT IS THE DIRECTION OF TREATMENT YOU ARE LOOKING FOR AT **NAKANO CHIROPRACTIC**?

- | | |
|--|---|
| <input type="checkbox"/> TO LESSEN CURRENT SYMPTOMS | <input type="checkbox"/> TO ELIMINATE CURRENT SYMPTOMS AND TAKE PREVENTATIVE MEASURES TO ALSO ELIMINATE THE UNDERLYING PROBLEM. |
| <input type="checkbox"/> TO ELIMINATE CURRENT SYMPTOMS | <input type="checkbox"/> TO DO ALL THAT IS POSSIBLE IN CREATING A HEALTHY AND YOUTHFUL LIFESTYLE . |

PLEASE LIST ALL MEDICATIONS/ VITAMINS/ HERBS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY ALLERGIES YOU MAY HAVE:

I DO HEREBY CERTIFY THAT THE PRECEDING QUESTIONS HAVE BEEN ANSWERED TRUTHFULLY AND COMPLETELY TO THE BEST OF MY KNOWLEDGE AND BELIEF

NAME

SIGNATURE

DATE