

PATIENT INFORMATION SHEET

670 Monterey Pass Road #100, Monterey Park, CA 91754 ☐ Phone: (626) 551-5155 ☐ Fax: (626) 551-5156 ☐
www.comfortchirowellness.com

Please complete this form as thoroughly as possible. Some questions may seem unrelated to your condition but they may affect your diagnosis and treatment. All information is confidential.

| | | | | | | |
|---|---------------|-----|--|-------------------------|-----|--|
| Date | Full Name | | | Preferred Name/Nickname | | |
| Gender | Date of Birth | Age | Marital Status Single Married Separated Divorced | | | |
| Address | | | City | State | Zip | |
| Daytime Phone # (home, work, cell - circle one) () | | | Cell Phone # (home, work, cell - circle one) () | | | |
| Emergency Contact & Relationship | | | Phone Numbers of Emergency Contact Primary () Alternate () | | | |
| Email: _____ Your email will be used to send appointment confirmations and for internal purposes only. | | | | | | |
| Primary Care Physician | | | Specialty | | | |
| Other Doctors You See | | | Specialty | | | |
| How did you hear about us? | | | | | | |
| Cancellation Policy - I acknowledge that I will give at least 24 hour notice of cancellation to avoid a charge for the session. This is a courtesy to other patients who may need that appointment time. I will call if I anticipate being more than 15 minutes late for my appointment. Initials _____ | | | | | | |

List your major complaint(s), in order of importance to you:

- | | Severe | Moderate | Slight | |
|----|--------------------------|--------------------------|--------------------------|-------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

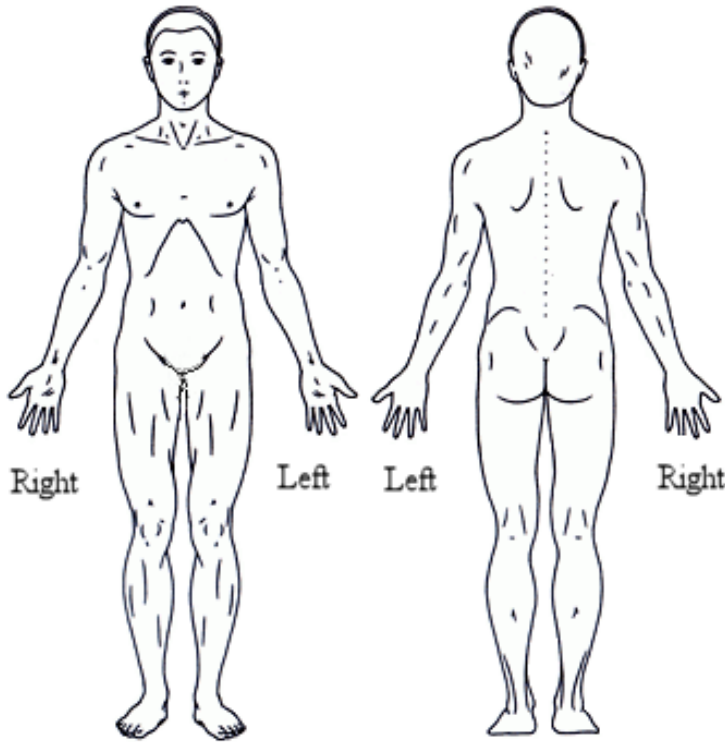
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Symptoms and Present State of Health

| | |
|--|--|
| Present Reason for Seeking Care in this Office: | Major _____ |
| Pain or Problem started on _____ | Pains are: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull/ Ache <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Other, Explain: _____ |
| Does this pain shoot, radiate, or travel in your body? Where? _____ | Are you experiencing numbness or tingling in any area of your body? Where? _____ |
| Since it began, is it: <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worst | What activities aggravate your condition/pain? _____ |
| What activities lessen your condition/pain? _____ | Is this condition worse during certain times of the day? _____ |
| Is this condition interfering with <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Routine <input type="checkbox"/> Other: _____ | Is this condition progressively getting worse? _____ |
| Other Doctors seen for this condition: _____ | |
| Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain) | |

***Using the symbols below, mark on the pictures where you feel pain.



- Numbness = = =
- Dull Ache 0 0 0
- Burning X X X
- Sharp/Stabbing // / /
- Pins, Needles + + +
- Other _____ ^ ^ ^

Please mark any of the following conditions or symptoms that you have now or have experienced:

| | | | |
|---|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in Hands or Arms | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Numbness in Hands / Arms | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Neck Stiffness/Pain | <input type="checkbox"/> Pain in Legs or Feet |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> TMJ | <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menopause | <input type="checkbox"/> Tension | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Weight Loss |

PRESENT ILLNESS

Please list all medical conditions you currently have or have had

FAMILY HISTORY

Please list all the relevant medical conditions of your immediate

Name: _____

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| <i>and the year diagnosed. Also include any accidents/injuries.</i> | | | <i>family members.</i> | |
|---|-----------|----------------|------------------------|-------------------|
| Year | Condition | Surgery (Y/N)? | Relation | Medical Condition |
| | | | | |
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| HEALTH HABITS <i>Please check (b) all that apply and indicate the amount consumed.</i> | | OCCUPATIONAL CONCERNS <i>Please check (b) all that apply and comment if necessary.</i> | |
| <input type="checkbox"/> Alcohol | | <input type="checkbox"/> Stress | |
| <input type="checkbox"/> Tobacco | | <input type="checkbox"/> Excessive Computer Use / Typing | |
| <input type="checkbox"/> Caffeine | | <input type="checkbox"/> Heavy Lifting | |
| <input type="checkbox"/> Sugar | | <input type="checkbox"/> Repetitive Motion | |
| <input type="checkbox"/> Art. Sweeteners | | <input type="checkbox"/> Hazardous Substances | |
| <input type="checkbox"/> Drugs | | <input type="checkbox"/> Other | |
| Other | | | |

| MEDICATIONS & SUPPLEMENTS <i>Please list all the prescription meds and supplements that you are currently taking as well as the duration and dosage. Please bring your medications and supplements with you to the first office visit.</i> | | | |
|--|---------|----------|--------|
| Name | Purpose | Duration | Dosage |
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| FEMALES ONLY | |
| Date of your last pap smear: ____/____/____ | Current form of birth control: _____ |
| Date of Last Period: ____/____/____ | How heavy is the bleeding? <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy |
| What color is the blood? <input type="checkbox"/> Light red <input type="checkbox"/> Red <input type="checkbox"/> Dark Red <input type="checkbox"/> Purple <input type="checkbox"/> Brown <input type="checkbox"/> Black | Is there clotting? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have premenstrual symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have breast tenderness before periods? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | # of Miscarriages _____ # of Abortions _____ |
| How many days in your cycle: _____ | Age at which menses began: _____ |

| |
|---|
| EXERCISE / STRESS RELIEF |
| How often do you exercise? _____ Which exercises do you do? _____ Do you enjoy exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How do you usually relieve stress? (yoga, meditation, smoking, watching tv, etc.) _____ |

