Bolt Chiropractic Family Wellness

445 W. Fifth Street., Oxnard, CA 93030

Don Bolt, D.C.

Name_____Address_____

City _____ State _____ Zip _____ Home Phone # _____ Cell # _____

Email: _____ SSN _____Referred To Us By? _____

Date of birth_____ Age_____ Height_____ Weight_____

Male Female Single Married Divorced Separated Widow # of children _____

Name Of Spouse (or parent) _____ Contact Number: _____

Your Employer _____ Address _____

City_____ State _____ Zip _____Work #_____ Occupation _____

What is the name of your family physician?_____ What city are they located in?_____

Have you ever had Chiropractic care before? _____ If yes, doctor name:_____ Date last visit_____

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity:

1._____ For how long? _____

2._____ For how long? _____

3._____ For how long? _____

4._____ For how long? _____

Has this problem been getting worse or staying the same?_____ Currently or in the past have you ever experienced any of these complaints while working?_____ If yes, please describe what activities at work may be causing you to experience these complaints:

_____

Have you at any time in the past ever suffered a work injury: _____ If yes, what is the date of injury? _____

Do you have an attorney representing you for this work injury? _____ If yes, who is your attorney? _____

Have you been involved in an auto accident in the last 12 months? _____ If yes, what is the date of the auto accident? _____

Do you have an attorney representing you for this auto accident? _____ If yes, who is your attorney? _____

How many other passengers were in the car with you? _____ Names: _____

List other doctors consulted for these conditions: 1._____ 2. _____

If due to an auto accident, what is the name of your auto insurance company? _____

_____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please circle all medications (over the counter and/or prescribed) you are currently taking: Aspirin/Tylenol Pain killers Muscle Relaxers Insulin Birth Control Pills Sleeping Pills Anti-Depressants Others:_____

_____

Health Insurance Co. Name _____ Policyholder _____

Subscriber ID # _____ Group #_____Phone #_____

Name of Secondary health insurance (If applicable)_____ Policyholder_____

Subscriber ID # _____Group #_____Phone #_____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition

(pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

_____

Completely able to function — **Totally unable to function**

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____

2. RECREATION: hobbies, sports, and other similar leisure time activities. _____

3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____

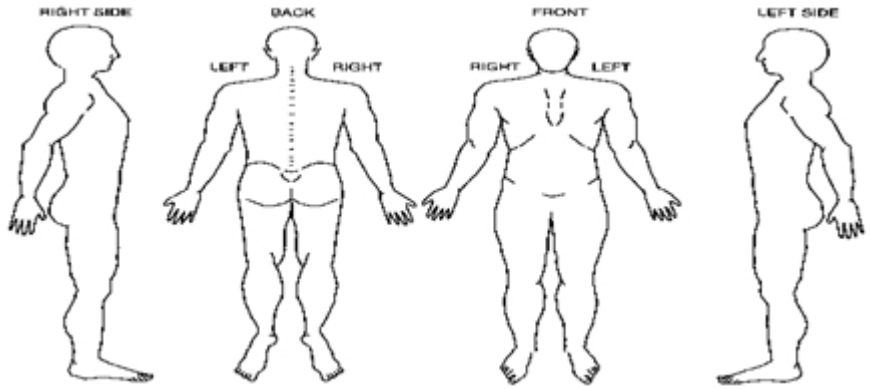
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as that of a homemaker or volunteer worker. _____

5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD** ☐ **OTHER** _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAYS ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.

2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature_____ **Date**_____