BIO CRANIAL SYSTEM
858-674-1117

RB Courtyard Chiropractic Center
The Center for Bio Cranial Therapy
16935 W. Bernardo Drive, Suite 224, San Diego, CA 92127

PATIENT INFORMATION FORM

Dr. Donna Martos Dr. Thomas Stuebe

c o n f i d e n t i a l

REASON FOR SEEKING CARE (part 2 of Patient Information Form)

☐ Optimizing/Maintaining My Health ☐ I have symptoms. If so, when did you first notice the symptoms?

Where specifically are your symptoms located?

Is your condition getting better, worse, or staying the same?

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other

Are your symptoms:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Rate the severity of your symptoms. (0= none to 10 = severe/unbearable) 0 1 2 3 4 5 6 7 8 9 10

Are your symptoms (% of the day)?

☐ Constant (90-100%) ☐ Frequent (50-75%) ☐ Intermittent (25-50%) ☐ Rare (<25%)

What makes your symptoms worse?

What makes your symptoms better?

What treatment(s) have you received for your condition: ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other

Name/Phone number of other doctor(s) you have seen for your condition; Dates of last exams; Surgeries; List of all medications:

Name: Phone: Date of last exam:

Surgeries:

Medications:

Name: Phone: Date of last exam:

Surgeries:

Medications:

HEALTH HISTORY

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Smoke? _____ cig/day
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Whooping Cough
- ☐ Other _____
- ☐ Other _____

Women only:

- ☐ Pregnant
- ☐ Nursing
- ☐ Birth control pills

Date of last menstrual cycle

_____ /_____/_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I agree to be responsible for payment of all services rendered on my behalf, or my dependents.

X _____ Date: _____

SIGNATURE OF PATIENT (or parent if a minor)