



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

**PATIENT INFORMATION FORM**

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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

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Mumps                | <input type="checkbox"/> Tumors, Growths     |
| <input type="checkbox"/> Allergy Shots       | <input type="checkbox"/> Fractures          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Vaginal Infections  |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Goiter             | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Whooping Cough      |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Gonorrhea          | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Gout               | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Polio                |  |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Prostate Problems    |  |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Prosthesis           | <b>Women only:</b>                           |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Pregnant            |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Nursing             |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Birth control pills |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Smoke? ____ cig/day  | Date of last menstrual cycle                 |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Measles            | <input type="checkbox"/> Stroke               | ____ / ____ / ____                           |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt      |  |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Thyroid Problems     |  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Tonsillitis          |  |

## 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)**