

# Welcome!

Swarthout Chiropractic  
8455 N. Millbrook Ave., Ste. 104  
Fresno, CA 93720

## Patient Information:

Name:	Date of Birth:	
Address:		
City:	State:	Zip:
Home ph#: (    )	Work ph#: (    )	Cell ph#: (    )
Social Security #:	Email:	
Male ___ Female ___	Marital: Single ___ Married ___ Divorced ___ Widowed___	
Occupation:	Employer:	
Employer's Address:		
Spouse's Name:		
Person to Contact In Case of Emergency:		
Emergency Contact Phone#:		

## Payment:

## Referred By:

<input type="checkbox"/> Work Related Injury/Worker's Compensation	How did you hear about us? Please check one:
<input type="checkbox"/> Medical/Group Insurance	<input type="checkbox"/> Personal Referral by:
<input type="checkbox"/> Cash	<input type="checkbox"/> Insurance Referral
<input type="checkbox"/> Motor Vehicle Accident	<input type="checkbox"/> Internet:
Have you retained an attorney? ___ Yes ___ No	<input type="checkbox"/> Search Engine ___ Insurance Company's Site
<input type="checkbox"/> Medicare Rate	<input type="checkbox"/> Other:

## Patient History:

Briefly describe your major complaint/purpose of this office visit (i.e. headaches, neck pain, etc):
Is this condition due to an accident? ___ Yes ___ No Date of Injury (if applicable):
Have you ever had this condition in the past? ___ Yes ___ No
If "yes" did you seek treatment? ___ Yes ___ No If "yes" was treatment effective? ___ Yes ___ No
Is the condition becoming progressively worse? ___ Yes ___ No
When did you first notice the problem?
Does it interfere with: ___ work ___ sleep ___ daily lifestyle ___ other:
Have you been treated for any other condition or injury in the past year? ___ Yes ___ No. If "yes" please explain:
Quality of Pain: ___ Achy ___ Dull ___ Burning ___ Numbness ___ Sharp ___ Stabbing ___ Stiff ___ Throbbing ___ Other:
Rate the level of pain according to the scale below.
0                      2                      4                      6                      8                      10
----->
No Pain                      Moderate Pain                      Severe Pain
Requiring Medication



## Current & Past Health History Continued

### Medical History

AIDS/HIV	Heart Attack
Alcoholism	Heart Disease
Anemia	Hepatitis
Aneurysm	Kidney Disease
Atherosclerosis	Liver Disease
Arthritis	Measles
Ankylosing Spond	Multiple Sclerosis
Osteo A.	Mumps
Rheumatic A.	Osteoporosis
Asthma	Pacemaker
Cancer	Pneumonia
Chataracts	Polio
Chicken Pox	Prostrate Problems
Diabetes	Prosthesis
Childhood Onset	Rheumatic Fever
Adult Onset	Scarlet Fever
Drug Dependency	Stroke
Epilepsy	Tuberculosis
Fracture	Tumors

### General Symptoms

Coughing up Blood  
 Depressed  
 Fainting Spells  
 Fatigue  
 Loss of Balance  
 Loss of Coordination  
 Loss of Sleep  
 Muscle Weakness  
 Shortness of Breath

Weight Loss

### Eye, Ear, Nose & Throat

Blurred Vision  
 Double Vision  
 Visual Disturbance  
 Hearing Loss  
 Ringing in Ears  
 Nose Bleeds  
 Bleeding Gums  
 Difficulty Swallowing  
 Persistent Cough

### Cardiovascular

Chest Pain  
 Cold Hands or Feet  
 High Blood Pressure  
 High Cholesterol  
 Irregular Heart Beat  
 Low Blood Pressure  
 Rapid Heart Beat  
 Swelling of Ankles  
 Other: \_\_\_\_\_

### Skin & Nails

Blue or Purple Skin  
 Blue or Purple  
 Nailbeds  
 Ridged Nails  
 Mole Changes  
 Non-Healing Sores  
 Slow Wound Healing  
 Yellow Skin

### Gastrointestinal

Excessive Thirst  
 Bloating  
 Feeling of  
 "Fullness"  
 Indigestion  
 Stomach Pain  
 Nausea  
 Vomiting  
 Diarrhea  
 Bloody Stool  
 Black, tarry stool  
 Hemorrhoids  
 Colitis  
 Other: \_\_\_\_\_

### Social History

Smoke \_\_\_\_\_  
 Other Tobacco \_\_\_\_\_  
 Alcohol \_\_\_\_\_  
 Family Stress \_\_\_\_\_  
 Work Stress \_\_\_\_\_  
 Crave Salt \_\_\_\_\_  
 Crave Sweets \_\_\_\_\_  
 Balanced Diet \_\_\_\_\_  
 Sufficient Rest \_\_\_\_\_  
 Exercise \_\_\_\_\_

### Genitourinary

Frequent Urination  
 Pain with Urination  
 Incontinence

### Women Only

Are you pregnant?	Yes	No	Date of Last OB/GYN exam: _____	Bleeding Between Periods
Type of Birth Control:			Abnormal Pap Smear	Heavy or Prolonged Bleeding
_____				
Date of Last Period:			Severe Menstrual Pain	Breast Lump(s)
_____				
Breast Augmentation	<input type="checkbox"/> Cancer		Cysts	Other: _____

I, the undersigned, certify that the above information is correct to the best of my knowledge and am solely responsible for any incorrect information I may have given or omissions I may have made.

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize treatment for my minor child as deemed necessary by my doctor.

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_