Plentiful Life Chiropractic Center

CONFIDENTIAL HEALTH INFORMATION

Dr. Jaime A. Chica D.C

Today's Date: _____ Chart Number:_____

Personal Information

First Name: _____ Middle:_____Last:_____

Address:_____ Apt: _____

City:_____ State_____ Zip:_____ Date of Birth:_____

Home Phone: ( )_____-_____ Social Security Number :_____

Cell Phone: ( )_____-_____ Gender: ❑ Male ❑ Female

Fax Number: ( )_____-_____ Marital Status: ❑ Married ❑ Single ❑ Divorced

Email Address: _____ ❑ Separated ❑ Widowed

Spouse's name if married: _____ Ages of children: _____

How did you hear about us? ❑ Outdoor Sign ❑ Yellow Pages ❑ Medical Physician ❑ Insurance ❑ Lawyer ❑ Online ❑ Family/Friend ❑ Other:_____

Employer

Business name: _____ Occupation:_____

Business Address: _____City_____ State:_____Zip:_____

Phone: ( )_____-_____ Fax Number: ( )_____-_____ Type of work: _____

Emergency Contact:

Name: _____ Relationship:_____ Phone Number: ( )_____-_____

Who is responsible for your bill? ❑ Self (Paying Cash) ❑ Self (Health Insurance) ❑ Medicare ❑ Auto Ins ❑ Worker's Comp ❑ Other:_____

Insurance Carrier: _____ **Who carries this policy?**

Health ID Card No: _____ ❑ Self ❑ Spouse ❑ Parent

Group No:_____

Insured Person's Name: _____ Insured Person's Birth date: _____

Primary Care Physician: _____ Phone Number: ( )_____-_____

Car Accident Insurance Information:

Date of Accident: _____ Where did accident occur? _____

Which Best Describes You: ❑ Driver ❑ Front Passenger ❑ Rear Passenger

Name of your Car Insurance: _____ Claim #_____

Name of Other Party's Car Insurance: _____Claim #_____

Do you have a Lawyer? ❑ Yes ❑ No Name of Lawyer: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Plentiful Life Chiropractic Center or insurance company to release any information required to process my claims.

X _____ _____

Patient/Guardian Signature Date

CLINICAL HISTORY

Name/Nombre:_____ Age/Edad_____ Sex: F ☐ M ☐
D.O.A. / Fecha del Accidente:_____

Dominant Hand / Mano Dominante R ☐ L ☐ Both / Ambas ☐

1. **Description of Accident / Injury / Onset / Chief Complaints**
   Descripción del accidente / Lesión / Aparición de los sintomas / Queja principal
   Entre la descripción completa del accidente, el trauma o como aparecieron los síntomas en el espacio de abajo

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. **Current Problem** (For your Dr. only / Para llenar por el medico solamente)

_____
_____
_____

FAMILY HISTORY / HISTORIA FAMILIAR
Mark with an X if anybody on your family (parents, relatives) suffer of any of the following illness:
Marque con una X si alguno de sus familiares (padres, hermanos, tíos, etc.) sufre o sufrió de:

Cancer	☐	Epilepsy	☐	Arthritis	☐	Kidney disease (Enfermedad del riñon)	☐
Tuberculosis	☐	Dementhia	☐	Hemophilia	☐	High Blood Pressure (Presión Alta)	☐
Diabetes	☐	Gout (Gota)	☐	Asthma	☐	Heart Disese (Enfermedad del Corazón)	☐

PERSONAL HISTORY / HISTORIA PERSONAL

Surgeries / Cirugías ☐ (Describe) _____
Hospitalization / Hospitalicación ☐ (Describe)_____
Medications that you are currently taking / Medicamentos que está tomando actualmente _____
_____
Auto Accident / Accidente de Carro Yes ☐ No ☐ When? / ¿Cuando? _____
Allergies / Alergias Yes ☐ No ☐ Smoke? / ¿Fuma? Yes ☐ No ☐ Ocasionally ☐ Frequently ☐
Drink alcoholic beverages? / Toma alcohol? Yes ☐ No ☐ Ocasionally ☐ Frequently ☐

GENERAL
Mark the most appropriate / Marque el mas apropiado

	Past	Present		Past	Present
Headaches / Dolor de Cabeza	☐	☐	Work Injury / Accidente de trabajo	☐	☐
Bleeding Disorders / Hemophilia	☐	☐	Veneral disease / Enfermedad venera	☐	☐
Psychiatric problems / Problemas mentales	☐	☐	Eating disorders / Problemas de apetito	☐	☐
Thyroid Disease / Enfermedad Tiroides	☐	☐	Drug dependency / Dependencia de drogas	☐	☐
Depression / Depresión	☐	☐	Dizziness / Mareos o vertigo	☐	☐

	Past	Present		Past	Present		Past	Present		Past	Present
Asthma	☐	☐	Cancer	☐	☐	Arthritis	☐	☐	Anemia	☐	☐
Epilepsy	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Hepatitis	☐	☐
Fever	☐	☐	Gout / Gota	☐	☐	Dermatitis	☐	☐	Vitamins	☐	☐

EENT / ORL

	Past	Present		Past	Present		Past	Present
Glaucoma	☐	☐	Visual impairment / No ve bien	☐	☐	Ear Infection / otitis	☐	☐
Cataracts	☐	☐	Tinitus / Ruidos en el oído	☐	☐	Sinusitis	☐	☐
Conjuntivitis	☐	☐	Loss of Hearing / Sordera	☐	☐	Nose Bleeding	☐	☐
Rhinitis	☐	☐	Persistent Cough / Tos Continua	☐	☐	Hoarseness / Ronquera	☐	☐

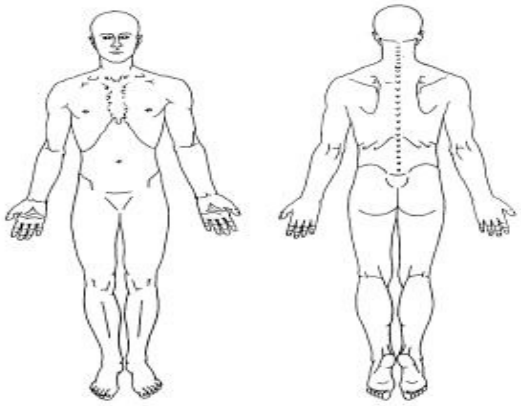
CARDIOVASCULAR - RESPIRATORY	Past ☐	Present ☐
High Blood Pressure / Presión Alta	☐	☐
Chest Pain / Dolor en el Pecho	☐	☐
Stroke / Infarto	☐	☐
Heart Disease / Enf. Corazón	☐	☐
Rheumatic Fever / Fiebre Reumática	☐	☐
Heart Murmur / Soplo Corazón	☐	☐
Ankle Swelling / Hinchazón de pies	☐	☐
Difficulty breathing, walking, sleeping / Dificultad en respirar, caminar, dormir	☐	☐
Chronic Cough / Tos Crónica	☐	☐
Spitting Phlegm / Tos con flema	☐	☐
Spitting blood / Tos con sangre	☐	☐
Pneumonia / Neumonia	☐	☐
Bronchitis / Bronquitis	☐	☐

GASTROINTESTINAL - G / U	Past ☐	Present ☐
Liver Disease / Enfermedad Hígado	☐	☐
Ulcer / Úlcera	☐	☐
Loss of Apetite / Perdida de Apetito	☐	☐
Flatulence (gas) / Gas Excesivo	☐	☐
Vomit, Nausea / Vómito, Nausea	☐	☐
Abdominal Pain / Dolor abdominal	☐	☐
Gall Bladder Stones / Cálculos Biliares	☐	☐
Hemorroids / Hemorroides	☐	☐
Constipation / Estreñimiento	☐	☐
Hernia	☐	☐
Jaundice / Ictericia	☐	☐
Kidney Stones / Cálculos de Riñon	☐	☐
Urinary Tract Infection / Infección Urinaria	☐	☐
Blood in Urine / Sangre en Orina	☐	☐
Difficulty Urinating / Dificultad al Orinar	☐	☐

REPRODUCTIVE	Past	Present
Pregnant / Embarazada	☐	☐
Irregular Menses / Regla Irregular	☐	☐
Abnormal Pap / Citología Anormal	☐	☐
Prostate Problem	☐	☐
Testicular Pain / Dolor de Testículo	☐	☐

MUSCULOSKELETAL AND NERVOUS SYSTEM	Past ☐	Present ☐
Low Back Pain / Dolor Bajo de Espalda (cintura)	☐	☐
Neck Pain / Dolor de Cuello	☐	☐
Pain between Shoulder Blades / Dolor de Espalda	☐	☐
Pain in Arms / Dolor en los Brazos	☐	☐
Pain in Legs - Sciatica / Dolor en Piernas - Sciatica	☐	☐
Muscle Cramps / Calambres Musculares	☐	☐
Loss of strength (pérdida de fuerza) in arms or legs	☐	☐
Numbness (adormecimiento) arms or legs	☐	☐
Loss of sensation arm or leg / Pérdida sensibilidad	☐	☐
Herniated Disc-Spine / Hernia Disco-Columna	☐	☐
Scoliosis / Columna Desviada	☐	☐
Fractures - Sprains / Fracturas - Torceduras	☐	☐
Osteoporosis	☐	☐
Short Leg / Pierna Corta	☐	☐

Point out with an X the areas of pain / Marque con una X las areas de dolor en las figuras de abajo



Additional Information

_____
_____
_____
_____
_____

Síntomas similars previos

☐ I have not had any symptoms siilar to my actual condition / No he tenido síntomas similares a mi condición actual

☐ I had my actual symptoms before, but they didn't bother me / Mis síntomas actuales los tuve antes, pero no me molestaban

☐ My actual symptoms already existed but they got worse after the accident / Mis síntomas actuales ya existían pero se empeoraron con el accidente

My most recent symptoms (if applicable) occurred / Mis síntomas similares mas recientes (si es aplicable) ocurrieron:

_____ ☐ months ago (meses atrás) / ☐ years ago (años atrás) or **on** Fecha (Date) __/__/__

Signature / Firma:_____

Date / Fecha _____