

Today's Date: _____
Referred By: _____

Yorba Linda Wellness Center New Patient Questionnaire

Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Phone: (H) _____ (w) _____ (cell) _____

Address: _____ City: _____ State _____ Zip: _____

Email Address: _____ Pt's SS# _____

Marital Status: S M D W / Spouse's Name _____

Children No Yes ages: _____

Occupation: _____ Employer _____ Hours worked / week _____

Health Information:

Date of injury? _____

Have you ever had the same condition? _____

What are your objectives in consulting our office? _____

What are your health goals once these objectives have been met? _____

Do you presently have any health problems, major or minor complaints? No Yes ... If yes, explain where and how much:

When did this problem start and how long have you had this? _____

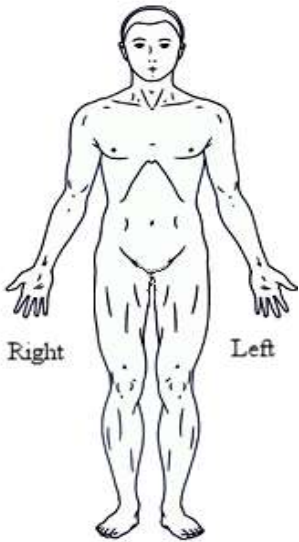
Current Health

What are your most pressing health concerns?

For how long? _____

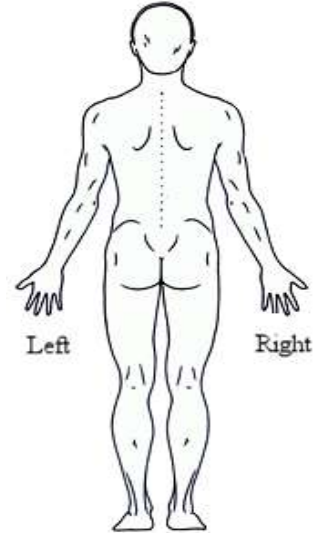
Is it getting worse improving intermittent
 constant can't say

Where is the problem? Please use the illustrations and lines below to explain



Front _____

Back _____



pain numbness tingling aches
Is your pain: sharp dull throbbing constant intermittent

Are your symptoms affected by:

sitting standing walking bending
 lying down weather

Please explain: _____

Do you feel: cramps burning other
 swelling stiffness _____

Do your symptoms interfere with (circle all that apply): work family sleep sex sports
recreation housework happiness ability to relax concentration
other _____

Have you had previous care for this condition? No Yes

Is it getting worse? No Yes, How? _____

At its worst, how does it feel? _____

Do you want to get rid of this condition? Yes No

Who was the last doctor who created a health development plan for you if any? _____

Did you follow all of the Doctor's recommendations? Yes No I was never put on a health plan

How long were you able to stay on the health development plan? _____

What were the results if any? _____

What other wellness professionals are currently a part of your health care team?

Massage Therapist Acupuncturist Naturopath Homeopath Other _____

How many Medical Doctor's office visits did you and your family have last year?

None Less than 5 More than 5 More than 10

Have you had previous Chiropractic Care? Yes No This year? Yes No

Were you ever put on a Spinal correction program? Yes No

If yes, by whom did you complete the program? _____

Patient Symptoms

Please mark as many symptoms or complaints

General Symptoms: (Mark as many as apply)

Nervousness Irritability Fatigue Depression Loss of sleep Tension Jaw Pain
 PMS

Head: (Mark as many as apply)

Headaches: Sharp Dull Migraine

Location: Back of head Forehead Temples Behind Eyes Left side Right Side

Light headed Memory loss Fainting Blurred vision Double vision Sensitivity to light
 Balance loss Hearing loss Ringing in ears

Pain level: 1 2 3 4 5 6 7 8 9 10

Frequency: 0-25% 26-50% 51-75% 76-100%

Neck: (Mark as many as apply)

Pain: Left side Right side Both

Pain increased by: Forward mvmt Backward mvmt Rotate head left Rotate head right
 Bend neck left Bend neck right Stiffness Mus. Spasm Grinding/Grating sounds

Pain level: 1 2 3 4 5 6 7 8 9 10

Frequency: 0-25% 26-50% 51-75% 76-100%

Shoulders: (Mark as many as apply)

Pain in joint: Left side Right side Both

Pain across shoulder: Left side Right side Both

Limitation in movement: Left side Right side Both

Tension: Left side Right side Both

Pain level: 1 2 3 4 5 6 7 8 9 10

Frequency: 0-25% 26-50% 51-75% 76-100%

Arm: (Mark as many as apply)

Pain in Upper Arm: Left side Right side Both

Pain in Elbow: Left side Right side Both

Pain in Forearm: Left side Right side Both

Pins & Needles(Arm): Left side Right side Both

Pins & Needles(Forearm): Left side Right side Both

Numbness in Arm: Left side Right side Both

Numbness in Forearm: Left side Right side Both

Pain level: 1 2 3 4 5 6 7 8 9 10

Frequency: 0-25% 26-50% 51-75% 76-100%

Chest: (Mark as many as apply)

Pain around ribs: Left side Right side Both

Deep chest pain: Left side Right side Both
 Shortness of breath Irregular heartbeat

Pain level: 1 2 3 4 5 6 7 8 9 10

Frequency: 0-25% 26-50% 51-75% 76-100%

Abdominal: (Mark as many as apply)

Nervous stomach Nausea Gas Constipation Diarrhea Heartburn
Loss of appetite Indigestion Pain

Pain level: 1 2 3 4 5 6 7 8 9 10

Frequency: 0-25% 26-50% 51-75% 76-100%

Low Back: (Mark as many as apply)

Upper Lumbar Pain: Left side Right side Both

Lower Lumbar Pain: Left side Right side Both

Sacro-iliac: Left side Right side Both

Muscle Spasm: Left side Right side Both

Pain level: 1 2 3 4 5 6 7 8 9 10

Frequency: 0-25% 26-50% 51-75% 76-100%

Hand: (Mark as many as apply)

Pain in wrist: Left side Right side Both

Pain in hand: Left side Right side Both

Pins & Needles (hand): Left side Right side Both

Numbness (hand): Left side Right side Both

Pain level: 1 2 3 4 5 6 7 8 9 10

Frequency: 0-25% 26-50% 51-75% 76-100%

Hips & Legs: (Mark as many as apply)

Pain in Buttocks: Left side Right side Both

Pain in Hip Joint: Left side Right side Both

Pain Down Leg: Left side Right side Both

Region- Front Back Side

Radiates to- Knee Calf Foot

Numbness Down Leg: Left side Right side Both

Region- Front Back Side

Pins & Needles (leg): Left side Right side Both

Region- Front Back Side

Knee Pain: Left side Right side Both

Leg Cramps: Left side Right side Both

Pain level: 1 2 3 4 5 6 7 8 9 10

Frequency: 0-25% 26-50% 51-75% 76-100%

Health History:

Please check all of the following health concerns you have experienced, even if you do not think that your answers relate to your present health concern.

- | | | | |
|-------------------------------|--|------------------------|--|
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Condition: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Immune System Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Infertility | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Menstrual Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mood Swings | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory/Vascular Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness/Tingling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Digestive Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Urinary Difficulty | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vertigo | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heartburn/Reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

List all previous surgeries and dates: _____

Have you ever had any broken bones/ fractures? _____

- List all Medications: Pain Meds (over the counter/prescription) Birth Control Heart Meds
 Cholesterol Meds Antidepressant/ Anti-anxiety Meds Recreational Drugs
 Anti-Inflammatory Meds Muscle Relaxers Aspirin Other _____

If you checked any of the above medications, please list how long you've been on each medication, dosage, and who prescribed them and for what reason are you taking them. It is important to let the doctor know in order to ensure proper interpretation of the diagnostic results with your spinal scans:

Do you have any family history of (please circle all that apply):

- Cancer Diabetes Heart Disease Arthritis Other _____

Stress History:

Please indicate whether you have ever experienced stress in any of the following areas. Your answer will enable us to determine which factors have contributed to your present health concerns.

1) Childhood

- | | | | |
|-----------------------------------|--|--------------------------|--|
| Repeated/Prolonged Antibiotic use | <input type="checkbox"/> Yes <input type="checkbox"/> No | Inhaler Use | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Car Accident | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prescription Medications | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Childhood Illness Yes No
Fall/Jump from a height < 3 feet Yes No
Fall/Jump from a height > 3 feet Yes No
Head Trauma Yes No

Surgery Yes No
Vaccination Yes No
Youth Sports Yes No
Other Traumas (physical or emotional)

2) Adulthood

Alcohol Consumption Yes No
Repeated/Prolonged Antibiotics Yes No
Car Accident Yes No
Coffee Drinker Yes No
Drug Use/Abuse Yes No
Fall/Jump from a height Yes No
Head Trauma Yes No
Home Environment Stress Yes No

Inhaler use Yes No
Prescription Medications Yes No
Smoker Yes No
Surgery Yes No
Contact Sports Yes No
Extreme Sports Yes No
Workplace Stress Yes No
Other Traumas (physical or emotional)

Lifestyle Information

Do you exercise? Yes No If yes, how much and how often? _____
Do you smoke? Yes No If yes, how much? _____
Do you consume alcohol? Yes No If yes, how much and how often? _____
Do you drink soft drinks (diet or regular)? Yes No If yes, how often? _____
Do you drink water? Yes No If yes, how much and how often? _____
Do you drink coffee? Yes No If yes, how much per day? _____
Do you rate your nutritional habits? Great Good Fair Poor
Do you take any vitamins/supplements? Yes No If yes, what kind? _____

Lifestyle information cont':

How many hours of sleep do you usually get? _____
Is it the quality of sleep: Great Good Fair Poor

Stress level (personal): Low Medium High
Stress level (at work): Low Medium High

What do you do to relieve or handle your stress? _____

Which best describes your reason for consulting the office?

- I have a specific concern and require help only with this
- I want to ensure that my health concerns do not become an ongoing problem that will impact my future health
- I want to be healthier five years from now than I am today

Who is responsible for this account? _____

Relationship to Patient _____

Would you like for us to verify your insurance eligibility? Yes No If yes, what is the name of your Insurance company? _____

Group #: _____ Subscriber's Name _____

Birthdate _____ SS# _____ Relationship to Patient _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. Kevin Shaevitz, DC all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chargers whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Date Relationship to Patient

Patient Signature (all information is filled out accurately to the best of my knowledge) Date