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 you 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?

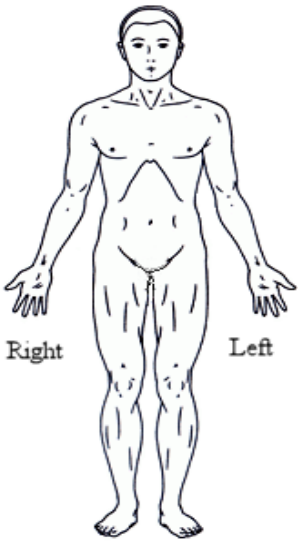
_____

_____

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 _____

_____

_____

_____

_____

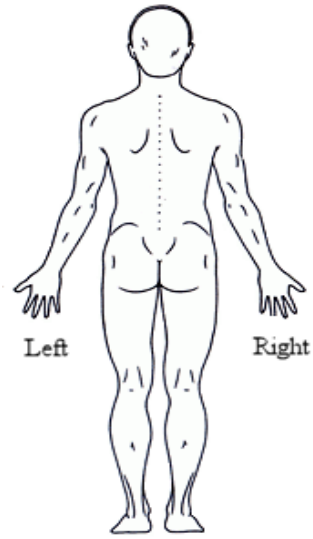
○ Back _____

_____

_____

_____

_____



○ 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%

Midback: (Mark as many as apply)

Pain: ○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%

Low Back: (Mark as many as apply)

Upper Lumber Pain: ○Left side ○Right side ○Both

Lower Lumber 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%

Activities of Daily Living

Please mark all of the functions below that you are unable to perform or having difficulty performing due to each of the conditions

Area of Pain

	Head	*Shoulder*	*Chest*	*Abs*	*Foot/Ankle*	*Neck*	*Mid-Back*	*Arm*	*Low-Back*	*Hand*	*Hip/Leg*
Personal Care											
○Eating	□	□	□	□	□	□	□	□	□	□	□
○Dressing	□	□	□	□	□	□	□	□	□	□	□
○Grooming	□	□	□	□	□	□	□	□	□	□	□
○Bathing	□	□	□	□	□	□	□	□	□	□	□
○Eliminating	□	□	□	□	□	□	□	□	□	□	□
Communication											
○Hearing	□	□	□	□	□	□	□	□	□	□	□
○Speaking	□	□	□	□	□	□	□	□	□	□	□
○Reading	□	□	□	□	□	□	□	□	□	□	□
○Writing	□	□	□	□	□	□	□	□	□	□	□
○Using a Keyboard	□	□	□	□	□	□	□	□	□	□	□
Activity											
○Sleeping	□	□	□	□	□	□	□	□	□	□	□
○Standing	□	□	□	□	□	□	□	□	□	□	□
○Walking	□	□	□	□	□	□	□	□	□	□	□
○Sitting	□	□	□	□	□	□	□	□	□	□	□
○Running	□	□	□	□	□	□	□	□	□	□	□
○Working	□	□	□	□	□	□	□	□	□	□	□
○Heavy lifting	□	□	□	□	□	□	□	□	□	□	□
○Medium lifting	□	□	□	□	□	□	□	□	□	□	□
○Light lifting	□	□	□	□	□	□	□	□	□	□	□
○Lifting weights	□	□	□	□	□	□	□	□	□	□	□
○Having sex	□	□	□	□	□	□	□	□	□	□	□
○During sports	□	□	□	□	□	□	□	□	□	□	□
○Working around house	□	□	□	□	□	□	□	□	□	□	□
○Working on hobbies	□	□	□	□	□	□	□	□	□	□	□
○Exercising	□	□	□	□	□	□	□	□	□	□	□
Sensory											
○Hearing	□	□	□	□	□	□	□	□	□	□	□
○Seeing	□	□	□	□	□	□	□	□	□	□	□
○Feeling	□	□	□	□	□	□	□	□	□	□	□
○Tasting	□	□	□	□	□	□	□	□	□	□	□
○Smelling	□	□	□	□	□	□	□	□	□	□	□
Recreation/Travel											
○Driving a car	□	□	□	□	□	□	□	□	□	□	□
○Riding in a car	□	□	□	□	□	□	□	□	□	□	□
○Riding in a boat	□	□	□	□	□	□	□	□	□	□	□
○Traveling in a boat	□	□	□	□	□	□	□	□	□	□	□
○Traveling in a train	□	□	□	□	□	□	□	□	□	□	□
Social Activities											
○Participating in group activities	□	□	□	□	□	□	□	□	□	□	□
○Speaking in public	□	□	□	□	□	□	□	□	□	□	□
○Emotional Stability	□	□	□	□	□	□	□	□	□	□	□

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	□ Yes	□ No	Heart Condition:	□ Yes	□ No
Anxiety	□ Yes	□ No	Immune System Disorder	□ Yes	□ No
Asthma	□ Yes	□ No	Infertility	□ Yes	□ No
Arthritis	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Back Pain	□ Yes	□ No	Menstrual Cramps	□ Yes	□ No
Bladder Problems	□ Yes	□ No	Mood Swings	□ Yes	□ No
Cancer	□ Yes	□ No	Neck Pain	□ Yes	□ No
Circulatory/Vascular Disorder	□ Yes	□ No	Numbness/Tingling	□ Yes	□ No
Depression	□ Yes	□ No	Osteoporosis	□ Yes	□ No
Diarrhea	□ Yes	□ No	Sinus Trouble	□ Yes	□ No
Digestive Problems	□ Yes	□ No	Skin Conditions	□ Yes	□ No
Dizziness	□ Yes	□ No	Urinary Difficulty	□ Yes	□ No
Headaches	□ Yes	□ No	Vertigo	□ Yes	□ No
Heartburn/Reflux	□ Yes	□ No	Other: _____	□ Yes	□ 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	□ Yes	□ No	Inhaler Use	□ Yes	□ No
Car Accident	□ Yes	□ No	Prescription Medications	□ Yes	□ No
Childhood Illness	□ Yes	□ No	Surgery	□ Yes	□ No

Fall/Jump from a height < 3 feet	□ Yes	□ No	Vaccination	□ Yes	□ No
Fall/Jump from a height > 3 feet	□ Yes	□ No	Youth Sports	□ Yes	□ No
Head Trauma	□ Yes	□ No	Other Traumas (physical or emotional)		
			_____		

2) Adulthood

Alcohol Consumption	□ Yes	□ No	Inhaler use	□ Yes	□ No
Repeated/Prolonged Antibiotics	□ Yes	□ No	Prescription Medications	□ Yes	□ No
Car Accident	□ Yes	□ No	Smoker	□ Yes	□ No
Coffee Drinker	□ Yes	□ No	Surgery	□ Yes	□ No
Drug Use/Abuse	□ Yes	□ No	Contact Sports	□ Yes	□ No
Fall/Jump from a height	□ Yes	□ No	Extreme Sports	□ Yes	□ No
Head Trauma	□ Yes	□ No	Workplace Stress	□ Yes	□ No
Home Environment 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 would 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