Crusade Specific Chiropractic - 1120 Corporate Way, Sacramento, CA 95831 - (916) 442-7474

Personal Information: Date: _____ Name_____ Date of Birth____/____/_____

Cell# *(for confirming appointment schedule)* _____ Home Phone _____

Address_____ City_____ State_____ Zip_____

Preferred Email Address *(for confirming appointment schedule)* _____

Age_____ Height_____ Weight_____ Sex_____ Status: Married____ Single____ Widowed____ Divorced____

Emergency Contact_____ Relationship_____ Phone#_____

Person responsible for this account_____ Relationship_____

Occupation_____ Referred by_____

Health Information: Have you ever had Chiropractic care before?_____ If yes, date of last visit?_____
If you are experiencing any pain (neck pain, mid back, low back, etc.), health problems, symptoms, and/or complaints, please list in order of severity.

1._____ For how long?_____

2._____ For how long?_____

3._____ For how long?_____

4._____ For how long?_____

Has this problem been getting _____worse _____staying the same? **Currently or in the past have you experienced any of these complaints while working?** Y____ N____ If yes, please explain:_____
Are there other activities, incidents, or events outside of work that may have caused these complaints? Y____ N____
If yes, please explain:_____

Any other medical conditions? Y____ N____ **If yes, please explain**_____
How would you rate your general health? ____Poor ____Good ____ Excellent
Are you currently seeking health care with another physician? Y____ N____ **If yes, physician name**_____
Contact#_____ **Have you recently had any x-rays or other tests?** Y____ N____ **Results**_____
Number of Children _____**List any past surgeries**_____

Please check all medications (over the counter and/or prescribed) you are currently taking: ___Apsrin/Tylenol ___Pain Killers ___Insulin ___Muscle Relaxers ___Birth Control ___ Sleeping Pills ___ Antidepressants ___Steroid medications (Prednisone, Cortisone) ___Anticoagulant medications ___Other (please list)_____
Do you: Smoke Y____ N____ How much_____ Exercise regularly Y____ N____ How often_____ Type of Exercise_____
Do you have any of the following? (check all that apply) ___Dizziness ___Headaches ___Ears Ringing ___Blackouts ___Diabetes ___High Blood Pressure ___Heart Disease ___Respiratory Issues

Insurance Information: Do you currently have medical insurance? Y____ N____ If yes, provider name?_____
For patients over 65, are you covered by Medicare? Y____ N____ Medicare ID#_____
Is your condition due to an accident? Y____ N____ Have you been in an auto accident in the last 12 months? Y____ N____
Have you been involved in an auto accident in the last 24 months? Y____ N____ If yes, what was the date of the accident?_____
Is your condition due to an accident at work? Y____ N____ If yes, what was the date of the accident?_____