CONFIDENTIAL
HEALTH INFORMATION

Pro Health & Rehab
Elizabeth Aliaga 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? ☐ Family/Friend ☐ Google ☐ Medical Physician ☐ Insurance ☐ Lawyer ☐ Online ☐ ☐ 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 Pro Health & Rehab or insurance company to release any information required to process my claims.

X _____ _____

Patient/Guardian Signature Date

CLINICAL HISTORY

Name: _____ Date: _____

☐ Automobile Accident ☐ Work Accident D.O.A: _____

CHIEF COMPLAINT

Pain Location: ☐ Head ☐ Neck ☐ Middle back ☐ Low back ☐ Chest ☐ Ribs ☐ R. Shoulder ☐ L. Shoulder ☐ R. Hand / Wrist. ☐ L. Hand / Wrist ☐ R. Knee. ☐ L. Knee ☐ R. Ankle / Foot. ☐ L. Ankle / Foot. ☐ Abdomen. ☐ Jaw

Explain:_____

_____

_____

Frequency: ☐ Constant. ☐ Occasional. ☐ Intermittent ☐ Frequent.

Pain Description: ☐ Achy ☐ Sharp ☐ Burning ☐ Dull ☐ Pounding. ☐ Stabbing ☐ Stiffness ☐ Radiating Leg / Arm L/R

Pain Progression: ☐ Same ☐ Getting Worst ☐ Improving ☐ Fluctuating

Severity: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

-------Mild ------ -------Moderate------- -------Severe-------

Additional Symptoms: ☐ Dizziness ☐ Nausea ☐ Anxiety ☐ Loss of smell ☐ Irritability ☐ Depression ☐ Confusion ☐ Arm numbness / tingling R or L? ☐ Pain behind eyes ☐ Breathing difficulties ☐ Sleeping difficulties ☐ Loss of taste ☐ Blurred vision ☐ Concentration difficulties ☐ Ringing ears ☐ Leg numbness / tingling R or L?

FAMILY HISTORY

Mark with an X if anybody on your family (parents, relatives) suffer of any of the following illness:

Cancer	☐	Epilepsy	☐	Arthritis	☐	Kidney disease	☐
Tuberculosis	☐	Dementhia	☐	Hemophilia	☐	High Blood Pressure	☐
Diabetes	☐	Gout	☐	Asthma	☐	Heart Disease	☐

PERSONAL HISTORY

Surgeries :☐ (Describe) _____

Hospitalization: ☐ (Describe)_____

Medications that you are currently taking :_____

_____

Auto Accident : Yes ☐ No ☐ When?: _____

Allergies: Yes ☐ No ☐ Smoke?: Yes ☐ No ☐ Ocasionally ☐ Frequently ☐

Drink alcoholic beverages? Yes ☐ No ☐ Ocasionally ☐ Frequently ☐

GENERAL

Mark the most appropriate:

	Past	Present		Past	Present
Headaches	☐	☐	Work Injury	☐	☐
Hemophilia	☐	☐	Venereal disease	☐	☐
Psychiatric problems	☐	☐	Eating disorders	☐	☐
Thyroid Disease	☐	☐	Drug dependency	☐	☐
Depression	☐	☐	Dizziness	☐	☐

	Past	Present		Past	Present		Past	Present		Past	Present
Asthma	☐	☐	Cancer	☐	☐	Arthritis	☐	☐	Anemia	☐	☐
Epilepsy	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Hepatitis	☐	☐
Fever	☐	☐	Gout	☐	☐	Aids	☐	☐	Vitamins	☐	☐

SKIN

Psoriasis	☐	☐	Eczema	☐	☐	Dermatitis	☐	☐	Herpes	☐	☐

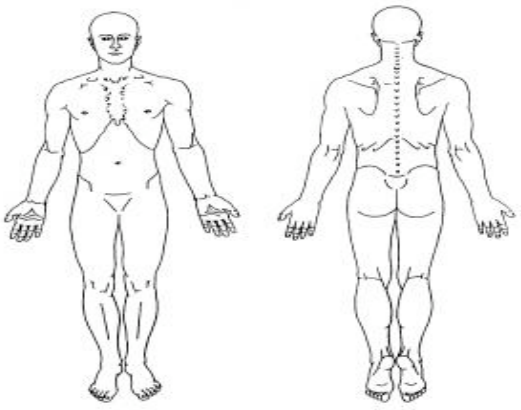
CLINICAL HISTORY

EENT	Past	Present		Past	Present		Past	Present
Glaucoma	☐	☐	Visual impairment	☐	☐	Otitis	☐	☐
Cataracts	☐	☐	Tinitus	☐	☐	Sinusitis	☐	☐
Conjuntivitis	☐	☐	Loss of Hearing	☐	☐	Nose Bleeding	☐	☐
Rhinitis	☐	☐	Persistent Cough	☐	☐	Hoarseness	☐	☐

CARDIOVASCULAR - RESPIRATORY	Past	Present	GASTROINTESTINAL - G / U	Past	Present
High Blood Pressure	☐	☐	Liver Disease	☐	☐
Chest Pain	☐	☐	Ulcer	☐	☐
Myocardial Infarction	☐	☐	Loss of Apetite	☐	☐
Heart Disease	☐	☐	Flatulence (gas)	☐	☐
Rheumatic Fever	☐	☐	Vomit, Nausea	☐	☐
Heart Murmur	☐	☐	Abdominal Pain	☐	☐
Ankle Swelling	☐	☐	Gall Bladder Stones	☐	☐
Difficulty breathing, walking, sleeping	☐	☐	Hemorrhoids	☐	☐
Chronic Cough	☐	☐	Constipation	☐	☐
Spitting Phlegm	☐	☐	Hernia	☐	☐
Spitting blood	☐	☐	Jaundice	☐	☐
Pneumonia	☐	☐	Kidney Stone	☐	☐
Bronchitis	☐	☐	Urinary Tract Infection	☐	☐
			Blood in Urine	☐	☐
			Difficulty Urinating	☐	☐

REPRODUCTIVE	Past	Present
Pregnant	☐	☐
Irregular Menses	☐	☐
Abnormal Pap	☐	☐
Prostate Problem	☐	☐
Testicular Pain	☐	☐

Mark with an X the places of pain



MUSCULOSKELETAL AND NERVOUS SYSTEM	Past	Present
Low Back Pain	☐	☐
Neck Pain	☐	☐
Pain between Shoulder Blades	☐	☐
Pain in Arms	☐	☐
Pain in Legs - Sciatica	☐	☐
Muscle Cramps	☐	☐
Loss of strength in arms or legs	☐	☐
Numbness arms or legs	☐	☐
Loss of sensation arm or leg	☐	☐
Herniated Disc-Spine	☐	☐
Scoliosis	☐	☐
Fractures - Sprains	☐	☐
Osteoporosis	☐	☐
Short Leg	☐	☐

Prior Similar Symptoms

☐ I have not had any symptoms similar to my actual condition
☐ I had my actual symptoms before, but they didn't bother me
☐ My actual symptoms already existed but they got worse after the accident
My most recent symptoms (if applicable) occurred: _____ ☐ months ago
_____ ☐ years ago or on Date: _____/_____/_____

Signature: _____ Date: _____