Pro Health & Rehab
Elizabeth Aliaga D.C.

CONFIDENTIAL
HEALTH INFORMATION

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: ____

Health ID Card No: ____

Group No:____

Who carries this policy?

❑Self ❑Spouse ❑Parent

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	☐	☐

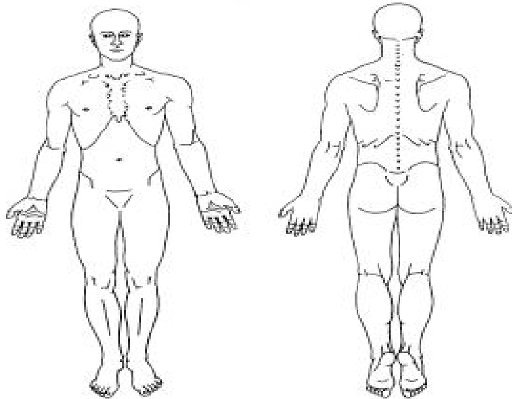
CARDIOVASCULAR - RESPIRATORY	Past	Present
	☐	☐
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Myocardial Infarction	☐	☐
Heart Disease	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Ankle Swelling	☐	☐
Difficulty breathing, walking, sleeping	☐	☐
Chronic Cough	☐	☐
Spitting Phlegm	☐	☐
Spitting blood	☐	☐
Pneumonia	☐	☐
Bronchitis	☐	☐
___________________________________		

GASTROINTESTINAL - G / U	Past	Present
	☐	☐
Liver Disease	☐	☐
Ulcer	☐	☐
Loss of Apetite	☐	☐
Flatulence (gas)	☐	☐
Vomit, Nausea	☐	☐
Abdominal Pain	☐	☐
Gall Bladder Stones	☐	☐
Hemorrhoids	☐	☐
Constipation	☐	☐
Hernia	☐	☐
Jaundice	☐	☐
Kidney Stone	☐	☐
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: ___________________________

Automobile Accident Description

Date of Accident: ______________ **Time of accident:** __________ **City of Accident:** _____________________

1. Your Vehicle Type
☐ Car ☐ Station Wagon
☐ Van ☐ Pickup truck
☐ Large Truck ☐ Bus
Model and year of your car: _________________________

2. Your position in vehicle
☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger

3. What was your car doing at the time of the accident?
☐ Stopped at intersection ☐ Stopped in traffic ☐ Stooped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Model and year of another car: ___________________________

4. Speed / Damage
Your vehicle's speed: ___mph
Other vehicle's speed :___mph

5. Details of Accident
Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

6. Road Conditions
Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and Dry

Damage to your vehicle
☐ Mild ☐ Moderate ☐ Total
Damage to other vehicle
☐ Mild ☐ Moderate ☐ Total

Who hit? Who what?
☐ You hit other vehicle
☐ Other vehicle hit you
☐ You hit___________

Point of impact
☐ Head-On ☐ Left front ☐ Right front
☐ Rear-End ☐ Left rear ☐ Right rear
☐ Left side ☐ Right side Other __________________

7. Body position, etc.
Did you see the accident coming? **Yes** ☐ **No** ☐
Were you braced for the impact? **Yes** ☐ **No** ☐
Did you have a seat belt on? **Yes** ☐ **No** ☐
Did you have a shoulder harness on ¿ **Yes** ☐ **No** ☐

Does your vehicle have headrests?? Yes ☐ **No** ☐
What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at the time of impact??
☐ Facing straight forward ☐ Turned to the right
☐ Turned to the left ☐ Down

8. Additional Accident Information /Additional vehicles involved in the crash
____
____
____

9. During the accident:
Did your body strike the inside of your car?? **Yes** ☐ **No** ☐
If yes, describe: ___________________________________
Did you lose consciousness? **Yes** ☐ **No** ☐ Min:_____
Did airbags deploy? **Yes** ☐ **No** ☐
☐ Driver ☐ Passenger ☐ R. Door ☐ L. Door
Were any objects thrown around the interior of the car?
☐ Eye Glasses ☐ Cell phone ☐ Food ☐ Nothing
Did your seat break? **Yes** ☐ **No** ☐
Did police show up at the scene? **Yes** ☐ **No** ☐
Was an accident report filled out? **Yes** ☐ **No** ☐
To whom the police issue a ticket? **You** ☐ **Other** ☐

10. After the accident:
Check off your symptoms right after and a few days following:
1-Pain on: ☐ Head ☐ Neck ☐ Middle back ☐ Low back☐ Chest
☐ Ribs ☐ R. Shoulder. ☐ L. Shoulder ☐ R. Hand. ☐ L. Hand
☐ R. Knee. ☐ L. Knee ☐ R. Ankle / Foot. ☐ L. Ankle / Foot.
☐ Abdomen. ☐ Jaw Other: _________________
2- Additional Symptoms: ☐ Dizziness ☐ Nausea ☐ Anxiety
☐ Loss of smell ☐ Irritability ☐ Depression ☐ Arm Numbness R or L?
☐ Pain behind eyes ☐ Breathing difficulties ☐ Sleeping difficulties
☐ Loss of taste ☐ Blurred vision ☐ Concentration difficulties
☐ Ringing ears ☐ Confusion ☐ Leg numbness and tingling R or L?

11. Emergency Room??
Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER. ☐ Private Doctor
How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were x-rays done? Yes ☐ **No** ☐ **Blood Work? Yes** ☐ **No**☐
Body parts x-rayed? ______________________________
What lab work? __________________________________
The x-rays revealed: ______________________________
Treatments: ☐ Cervical Collar ☐ Ice ☐ Other ________
Medications: ____________________________________
Follow-up instructions: ___________________________
____

12. Treatment History
Doctors seen prior to your first visit to this office
1. Dr. ___________________ First visit date: ___/___/___
Specialty: ______________X-rays done? **Yes** ☐ **No** ☐
Type of Treatment received: _________________________________
How many treatments received? ____ Currently treating? **Yes** ☐ **No** ☐
Did treatments Benefit you?? **Yes** ☐ **No** ☐
Date of last visit: ___/___/___
2. Dr. ___________________ date of first visit: ___/___/___
Type of treatment received: _________________________________
How many treatments received? _____ Currently treating? **Yes** ☐ **No** ☐
Did treatments benefit you? **Yes** ☐ **No** ☐
Date of last visit: ___/___/___

Signature: _________________________________ Date _________________