

# Moncado Chiropractic ~ Health History

1602 Idaho Ave, Escondido, CA 92027

(858) 722-9222

cranialnerve579@gmail.com

Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: S M D W # of children: \_\_\_\_\_

Spouse/Partner Name \_\_\_\_\_ Spouse/Partner Age \_\_\_\_\_

**Financial Information:** Who is responsible for this account? \_\_\_\_\_

**Reason Seeking Care:** Pain/Injury Related YES NO Wellness/Health Maintenance YES NO

**Accidents:** Please list other accidents, include dates. (car, bicycle, motorcycle, sports, falls at work or home)

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**Surgeries/Conditions:** Please list major surgeries, broken bones or conditions, include dates.

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**Medications:** Please list prescription & over-the-counter medications you are currently taking & their purpose.

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**Have you been to a chiropractor before? YES NO**

**Briefly describe that experience:**

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**Did the last chiropractor adjust your spine? YES NO**

**If yes, was there a "popping" sound when they adjusted you? YES NO**

**If yes please explain to the best of your ability what causes that "popping" sound:**

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**Expectations of care.** How many visits to our office do you anticipate? \_\_\_\_\_

**If you are here due to an injury or pain please describe what happened:**

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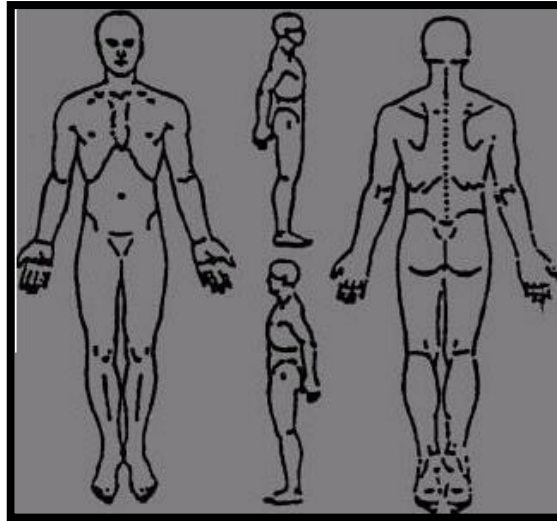


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Please mark your areas of pain on the figures by indicating the appropriate location of pain and the symbol that best describes your discomfort.



- Sharp & Stabbing            A
- Dull & Achy                    B
- Pins & Needles                C
- Numbness                        D
- Temperature Change        E

**Please score all of the following on a scale of 1-10, based on your current condition.**

- Pain:** 1=no pain, 10=worst pain you have ever had \_\_\_\_\_
- Personal care:** (washing, dressing, etc.) \_\_\_\_\_
- 1=I can take care of myself with no extra pain, 10=I can't take care of myself at all \_\_\_\_\_
- Lifting:** 1=I can lift with no extra pain, 10=I can't lift at all due to \_\_\_\_\_
- Reading:** 1=I can read with no extra pain, 10= I can't read at all due to pain \_\_\_\_\_
- Headaches:** 1=no headaches, 10=worst headaches I have ever had \_\_\_\_\_
- Concentration:** 1=I can concentrate fully, 10=I can't concentrate at all \_\_\_\_\_
- Work:** 1=I can work as much as I want, 10=I can't work at all \_\_\_\_\_
- Driving:** 1=I can drive with no pain, 10=I can't drive due to pain \_\_\_\_\_
- Sleeping:** 1=I sleep fine, 10=I can't sleep at all \_\_\_\_\_

If you CAN POSSIBLY answer YES, circle YES    If you MUST answer NO, circle NO  
 Please answer all questions. If you are not sure do your best.

- Has your eyesight blacked out completely?.....YES            NO
- Have you fainted more than twice in your life?            YES            NO
- Were you ever knocked unconscious?.....YES            NO
- Are you hard of hearing?            YES            NO
- Do you have allergies?.....YES            NO
- Have you ever coughed up blood?            YES            NO
- Have you suffered frequent cramps in your legs? ..... YES            NO
- Has a doctor ever said you had heart problems?            YES            NO
- Has a doctor ever said you had ulcers?.....YES            NO
- Does pressure or pain in your head often make life miserable?            YES            NO
- Have you or a family member ever had convulsions or epilepsy? Who?.....YES            NO
- Did a doctor ever treat you for a tumor or cancer?            YES            NO
- Are you frequently ill?.....YES            NO
- Are you considered a nervous person?            YES            NO
- Has a doctor ever said your blood pressure was too high..... YES            NO
- Have you been told you have osteoporosis?            YES            NO
- Have you been told you have rheumatoid arthritis?..... YES            NO

## Health Survey

In our chiropractic office we provide many services for your health. To get an idea of what you want and expect please take the following survey.

How would you rate your current health? Poor Fair Average Good Excellent

Do you want to live a long & healthy life? Yes No

If you answered yes above, how much time **per day** outside our office are you willing to commit to this goal?

\_\_\_\_\_hours \_\_\_\_\_minutes

Please score yourself from 1 to 10 below in each health category and then indicate if you are interested in receiving help in these areas. You can select as many or as few as you like.

Musculoskeletal pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)

I would like help and/or info on decreasing my pain: Yes No

Diet and nutrition: 1 2 3 4 5 6 7 8 9 10 (1 horrible diet, 10 excellent diet)

I would like help and/or info on improving my diet and nutrition: Yes No

Exercise program: 1 2 3 4 5 6 7 8 9 10 (1 horrible exercise habits, 10 excellent exercise habits)

I would like help and/or info on exercise: Yes No

Ability to sleep well: 1 2 3 4 5 6 7 8 9 10 (1 horrible sleeper, 10 excellent sleeper)

I would like help and/or info on getting a good nights sleep: Yes No

Stress level: 1 2 3 4 5 6 7 8 9 10 (1 no stress at all, 10 extreme stress)

I would like help and/or info on decreasing my stress: Yes No

Headache frequency: 1 2 3 4 5 6 7 8 9 10 (1 constant headaches, 10 never)

I would like help and/or info on decreasing my headaches: Yes No

Pharmaceutical drug intake: 1 2 3 4 5 6 7 8 9 10 (1 daily intake, 10 never)

I would like help and/or info on alternative solutions: Yes No

Energy Level: 1 2 3 4 5 6 7 8 9 10 (1 no energy at all, 10 endless energy)

I would like help and/or info on increasing my energy level: Yes No

Other areas of health that you may need help:

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Sign: \_\_\_\_\_

Date: \_\_\_\_\_