Bolt Chiropractic Family Wellness
433 W. Channel Islands Blvd.
Port Hueneme, CA 93041

Name______________________________Address______________________________

City ______________ State ________ Zip ________ Home phn __________ Cell phn ______________

Work phn ______________ Email: ______________________ SSN ______________________

Date of birth______________ Age__________ Height__________ Weight__________

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ # of children __________

Name of spouse (or parent) ______________________ Contact number: ______________________

Employer ______________________ Address ______________________________

City______________ State __________ Zip __________ Occupation ______________

What is the name of your family physician?__________________ What city are they located in?______________

Have you ever had Chiropractic care before? ______ If yes, doctor name:________________ Date last visit__________

If you are experiencing any pain (neck pain, mid back pain, low back pain, 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 or staying the same?________ Currently or in the past have you ever experienced any of these complaints while working?______ If yes, please describe what activities at work may be causing you to experience these complaints:

____

Have you at any time in the past ever suffered a work injury: ______ If yes, what is the date of injury? ______________

Do you have an attorney representing you for this work injury? ______ If yes, who is your attorney? ______________

Have you been involved in an auto accident in the last 12 months? ______ If yes, what is the date of the auto accident? __________

Do you have an attorney representing you for this auto accident? ______ If yes, who is your attorney? ______________

How many other passengers were in the car with you? ______ Names: ______________________

List other doctors consulted for these conditions: 1.______________________ 2. ______________

If due to an auto accident, what is the name of your auto insurance company? ______________________

____

Have you ever had any surgeries or hospitalizations? ______ If yes, please list: ______________________

Please circle all medications (over the counter and/or prescribed) you are currently taking: Aspirin/Tylenol Pain killers Muscle Relaxers Insulin Birth Control Pills Sleeping Pills Anti-Depressants Others:______________________

____

Health Insurance Co. Name ______________________ Policyholder ______________

Subscriber ID # ______________________ Group number______________

Name of Spouse's health insurance (If applicable)______________ Policyholder______________

Subscriber ID # ______________________ Group number______________

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) ________
2. RECREATION: hobbies, sports, and other similar leisure time activities. ________
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. ________
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. ________
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) ________
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. ________

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS

Method of payment for today's charges: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ ________________

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature ________________________________ Date ________________