PLEASANT HILL CHIROPRACTIC

Dr. Corey Piva

Patient Information Sheet

Patient Name____ Date:________________

Home Address ____

City: ______________________________ State: ____________ Zip: _____________________

Home Phone: ______________________ Work: ____________________ Cell: ______________

Social Security #: ____________________________ Date of Birth: _______________________

E-Mail: ____ (For Newsletter)

Marital Status: Single________ Married __________ Divorced ___________ Widowed: ___________

Employer: _____________________________ Address _______________________________

Name of Spouse: ____________________ Spouse SSN: ____________ Date of Birth: ___________

Primary Care Physician ___________________________ Phone# __________________________

Do you smoke? ________ Yes _________ No Drink caffeine beverages? ______Yes ______ No

Drink Alcoholic beverages? _____Yes _____No Hours of Sleep? ____6-8 ____ 8-10 ____11+ hours

Well Balanced diet: _____Never ____Rarely ____ Occasionally ____ Moderately

Frequency of exercise: _____Never ____Rarely ____ Occasionally ____ Moderately

Do you have a pacemaker ______Yes _____ No

Are you pregnant or do you think you may be pregnant? ______Yes _____ No

How did you hear about Pleasant Hill Chiropractic?

____Newspaper _____ Phone Book _____ Website _____ Relative _____ Friend ___Drove By

Whom may we thank for referring us to you? ____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize PHC to release any information acquired in the course of my medical examination and treatment to my insurance carrier(s) as necessary to process my insurance. I further authorize my insurance carrier(s) to make payment directly to PHC for the Chiropractic and/or medical benefits payable for the services rendered.

________________________________ ____________________________

PATIENT SIGNATURE DATE

Chief Complaint____

Describe the circumstances and what makes the conditions(s) better/worse: ________________________

____

How often do you experience this pain? __Constant __Frequent ___Intermittent ___ Occasionally

Severity of pain: (Please circle) "No pain" 0 1 2 3 4 5 6 7 8 9 10 "Severe Pain"

Have you seen another Dr (physician, Chiropractor, Acupuncture) for this condition?

Name________________

Is condition from an Accident? ____ Yes ____No Automobile ______ Work ______

Past Problem	Year and Details		SURGERY	Yes	No	Year
Cancer			**Stomach**			
Stroke			**Appendix**			
Thyroid			**Hernia**			
Asthma			**Gall Bladder**			
Heart Attack			**Colon**			
Diabetes			**Heart**			
Gout			**Kidney**			
Broken Bone			**Other**			
Arthritis			**MEDICINES**			
Depression			**Insulin**			
Kidney			**Thyroid**			
Bladder			**Blood Pressure**			
Numbness			**Pain**			
Dizziness			**Other**			
Headaches						
Insomnia			**DOCTORS NOTES:**			
Spasms						
Leg Problem						
Sinus						
Allergy						
Nausea						