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 # _____
Race: __White __African American __American Indian __More than one race __Other
Language: __English __Spanish __French __German __Italian __Other
Ethnicity: __Not Hispanic or Latino __ Hispanic or Latino
Do you smoke? __Current Everyday __Current Some Days __Former __Never __Unknown
Drink caffeine beverages? ___Yes ___No Drink Alcoholic beverage? ___Yes ___No
Hours of Sleep? ___6-8 hours ___8-10 hours __11+ hours
Well Balanced Diet: _____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? _____

Current Medication:_____
_____
_____
Known Drug Allergies:_____
_____
_____

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**

Pleasant Hill Chiropractic Cont.

Chief Complaint_____
Describe the circumstances and what makes the conditions 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, Chiropractic, Acupuncture) for the condition? __Yes __No
Name:_____
Is condition from an Accident? __Yes __No __Automobile __Work
Height_____ Weight _____ Vitals _____/_____

Past Problem	**Year and Details**		**Surgery**	**Year**
Cancer			Stomach	
Stroke			Appendix	
Thyroid			Hernia	
Asthma			Gall Bladder	
Heart Attack			Colon	
Diabetes			Heart	
Gout			Kidney	
Broken Bones			Other	
Arthritis				
Depression			**MEDICINES**	
Kidney			Insulin	
Bladder			Thyroid	
Numbness			Blood Pressure	
Dizziness			Pain	
Headaches			Other	
Insomnia				
Spasms				
Leg Problem				
Sinus				
Allergy				
Nausea				

Doctors Notes:_____
_____
_____
_____
_____