CULLINS CHIROPRACTIC CLINIC
220 S. LYON STE. C
HEMET, CA 92543
(951) 925-7609

PATIENT INFORMATION

First Name:__________MI:_____Last Name:____________ M / F

Street: ______________________________ Apt: ________

City:__________________________State:________Zip:________

Social Security #_________ DOB:_______ Marital Status: SMWD

Home Phone:______________Work Phone:____________ Ext:____

Cell Phone:_________________ Email:______________________

Emergency Contact: ___________________________________

Occupation:___________________Employer:_________________

Whom may we thank for referring you to our office?_____________

Drivers License #____________________

INSURANCE DEPARTMENT

Are you the policy holder? Y/N If no who is policy holder:_________

First Name: ___________MI:______ Last Name:_____________

Policy Holder's Date of Birth: ______ Policy Holder's SS#________

Do you have secondary coverage ? Y/ N If yes complete the following:

Policy Holder's Name: ________Policy Holder's SS#__________

CULLINS CHIROPRACTIC CLINIC
PATIENT'S HEALTH QUESTIONNAIRE

Name ______________________________ Date __________

Address ______________________ City ____________ State ______ Zip ________

Telephone ______________ Social Security# ______________ Driver Lic.# ______________

Age ______ Birthdate ____/____/____ Sex M / F Status M S W D No. Children ______

Occupation ______________ Employer ______________ Years Employed ______

Address ______________________ City ____________ State ______ Zip ________

Spouse's Name ______________ Occupation ______________ Employer ______________ Soc. Sec.# ______________

Person Responsible for this Account ______________________ Health Plan ______________

Subscriber's Name ______________________ ID# ______________ Group# ______________

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: ____/____/____ ______________

____

____

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Describe your current pain/symptoms:	☐ Sharp/Stabbing	☐ Throbbing	☐ Aches
	☐ Dull	☐ Soreness	☐ Weakness
	☐ Numbness	☐ Shooting	☐ Gripping
	☐ Burning	☐ Tingling	☐ Other ______
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change
What makes the problem better?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ Inactivity/rest	☐ Other ______
What makes the problem worse?	☐ Nothing	☐ Lying Down	☐ Walking
	☐ Standing	☐ Sitting	☐ Movement
	☐ Exercise	☐ Inactivity/rest	☐ Other ______
Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all
Describe your job requirements:	☐ Mainly sitting	☐ Light Labor	☐ Heavy Labor
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

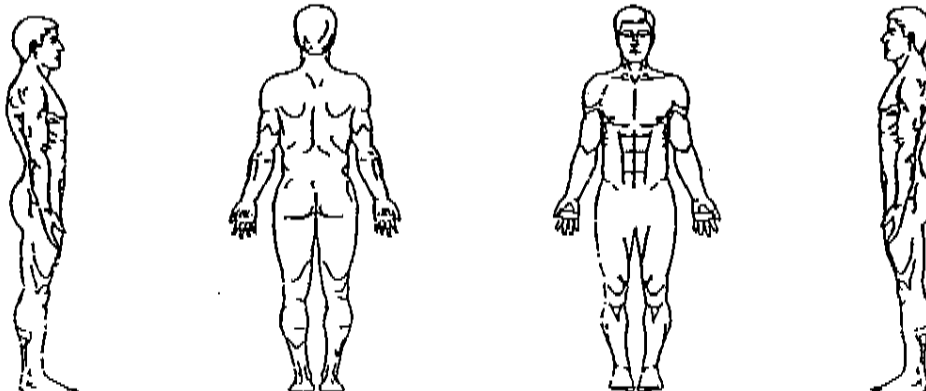
____

____

Have you had X-rays, MRI or other tests for this condition? What tests and When? ______________

____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient Signature: ______________________ Date: ______________

CULLINS CHIROPRACTIC CLINIC
PATIENT'S HEALTH QUESTIONNAIRE

Patient Name ______________________________ Patient ID# ____________________

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R_____ L_____)
☐	☐	Pain in Upper Arm or Elbow (R_____ L_____)
☐	☐	Hand Pain (R_____ L_____)
☐	☐	Wrist Pain (R_____ L_____)
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R_____ L_____)
☐	☐	Pain in Lower Leg or Knee (R_____ L_____)
☐	☐	Pain in Ankle or Foot (R_____ L_____)
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Breast ☐ Soreness ☐ Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Past	Present	Condition
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (date) ____________
☐	☐	Stroke (date) ____________
☐	☐	Asthma
☐	☐	Cancer, Explain ____________
☐	☐	Tumor, Explain ____________
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver / Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other____________

If a family member has had any of the following, please mark the appropriate box:

- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ High Blood Pressure
- ☐ Epilepsy
- ☐ Chronic Back Problems
- ☐ Chronic Headaches
- ☐ Lupus
- ☐ Other____________ ____________

Yes	No	
☐	☐	Do you have a permanent disability rating? Location ____________
☐	☐	Date rating received ____/____/____
☐	☐	Rating Percentage________%

Present Weight _______pounds **Height** _______feet _______inches

Patient Signature: ______________________________ Date: ________________