Summit Chiropractic
Dr. Kent G. Carlomagno
710 C.Street., # 12
San Rafael, Ca 94901
(415) 721-7520

CONFIDENTIAL PATIENT INTAKE FORM

HOW DID YOU HEAR ABOUT THIS CLINIC? [ ] HEALTH SCREENING [ ] PHONE BOOK [ ] AD [ ] REFERRAL, BY WHOM _____

PATIENT DATA

NAME_____ADDRESS_____

CITY _____ STATE ___ZIP _____ HOME PHONE _____ WORK PHONE _____ AGE___ BIRTHDATE_____

MARITAL STATUS ____ NO. OF CHILDREN ___ SOCIAL SECURITY NO. _____ DRIVERS LIC. NO._____

OCCUPATION/BUSINESS _____ EMPLOYER _____ ADDRESS _____

ACCIDENTAL INJURY REPORT

DATE OF ACCIDENT _____ HOUR _____ AM / PM LOCATION _____

HOW DID ACCIDENT OCCUR? [ ] AUTO COLLISION [ ] OTHER _____

PLEASE DESCRIBE THE CIRCUMSTANCES _____

_____

IF AUTO ACCIDENT WERE YOU-[ ] DRIVER [ ] PASSENGER [ ] OTHER _____

NAME, ADDRESS & PHONE NO.OF **DRIVER'S** AUTO INS.CO._____

DOES **DRIVER** HAVE MEDICAL PAYMENTS COVERAGE? _____ WHAT IS THE AMOUNT? $_____ HAS CLAIM BEEN REPORTED TO DRIVER'S INS. CO.? _____ CLAIM NO._____ NAME, ADDRESS & PHONE NO. OF ATTORNEY YOU MAY HAVE RETAINED FOR THIS CASE _____

_____

ON-THE-JOB INJURY REPORT

EMPLOYER _____ADDRESS _____ PHONE _____DID YOU REPORT INJURY TO SUPERVISOR PERSONNEL? [ ] YES [ ] NO . NAME OF SUPERVISOR OR PERSON REPORTED TO _____

PLEASE DESCRIBE THE CIRCUMSTANCES OF THE ACCIDENT AND THE AREA OF YOUR BODY THAT WAS INJURED _____

_____

_____

INSURANCE DATA

NAME OF INS. CO._____DO YOU HAVE YOUR INS. CARD WITH YOU SO THAT WE CAN MAKE A COPY OF IT? [ ] YES [ ] NO

IF NO, PROVIDE US WITH THE FOLLOWING INFORMATION: INS. CO. ADDRESS & PHONE NO. _____

I.D. # _____ GROUP # _____ NAME OF INSURED _____ INSURED'S EMPLOYER _____

I understand & agree that health & accident ins. policies are an arrangement between an ins. carrier & myself. Furthermore, I understand that this office will prepare any necessary reports & forms to assist in making collections from the ins. co. & that any amount authorized to be paid directly to this office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand & agree that all services rendered me are charged directly to me & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered me will be immediately due and payable. Overdue accounts will be charge 1 ½% interest compounded yearly.

PATIENT'S SIGNATURE_____ DATE _____

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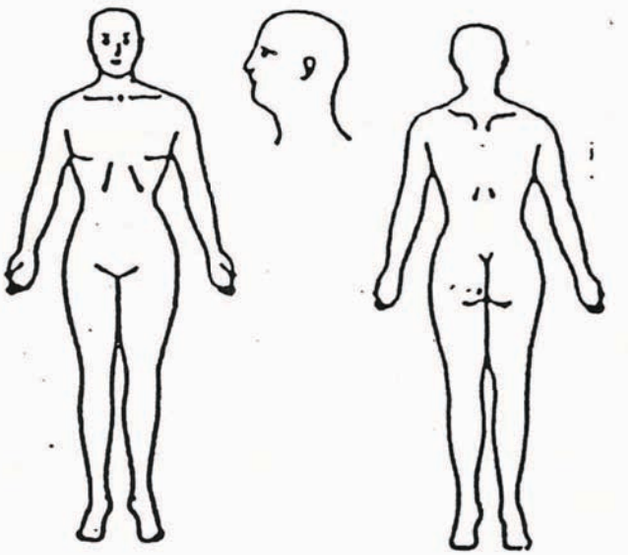
HEALTH HISTORY



Please mark your areas of pain on the figures below:

LIST MAJOR COMPLAINT (S) _____
_____
WHEN DID YOU FIRST NOTICE THIS? _____
HAS IT HAPPENED BEFORE? _____
IS IT WORSE IN AM / PM? _____
ANY RADIATION OF PAIN INTO ARMS & LEGS? _____
IS IT A SHARP OR DULL PAIN? _____
IS IT CONSTANT OR DOES IT COME & GO? _____
OTHER DR(S). SEEN FOR CONDITION _____
DID ANYONE RECOMMEND SURGERY? [ ] YES [ ] NO
ANY MEDICATION TAKEN FOR THIS CONDITION? _____
ARE YOU ON A SPECIAL DIET? _____
ARE YOU PREGNANT? _____
HOW DOES THIS PROBLEM ADVERSELY AFFECT YOUR LIFE? _____
DO YOU SMOKE? [ ] YES [ ] NO _____ DO YOU DRINK ALCOHOL [ ] YES [ ] NO _____
COFFEE OR CAFFINE BEVERAGES [ ] YES [ ] NO _____
DO YOU USE ANY RECREATIONAL DRUGS [ ] YES [ ] NO _____
DO YOU EXERCISE? [ ] YES [ ] NO WHAT KIND OF ACTIVITY & HOW OFTEN? _____
WHAT IS YOUR DEFINITION OF HEALTH? _____
ON A SCALE FROM 1 TO 10 HOW IMPORTANT IS YOUR HEALTH TO YOU? _____
I REMEMBER IMPORTANT THINGS IN MY LIFE BY WHAT I.....[ ] SEE [ ] HEAR [ ] FEEL

GENERAL PROBLEMS WITH THE FOLLOWING:

PLEASE CIRCLE YES OR NO	FREQUENCY	DURATION
1. HEADACHES YES / NO		
2. DIZZINESS YES / NO		
3. BLURRED VISION YES / NO		
4. BUZZING/RINGING EARS		
5. DEPRESSION YES / NO		
6. NERVOUSNESS YES / NO		
7. DIFFICULTY SLEEPING YES / NO		
8. LOSS OF ENERGY YES / NO		
9. SINUSES YES / NO		
10. NECK PAIN/STIFF YES / NO		
11. SHOULDER PROBS. YES / NO		
12. UPPER BACK YES / NO		
13. MID BACK YES / NO		
14. CHEST PAIN YES / NO		
15. LUNG YES / NO		
16. HEART YES / NO		
17. STOMACH YES / NO		
18. CONSTIPATION YES / NO		
19. LIVER YES / NO		
20. KIDNEY YES / NO		
21. BLADDER YES / NO		
22. LOW BACK YES / NO		
23. HIPS YES / NO		
24. LEG PAIN/CRAMPS YES / NO		
25. POOR CIRCULATION YES / NO		

PREVIOUS CONDITIONS/INJURIES

1. HOSPITAL/SURGERY YES / NO _____
2. ACCIDENTS/FALLS YES / NO _____
3. ACCIDENTS/JOB YES / NO _____
3. HAVE YOUR MOTHER, FATHER OR SIBLINGS HAD ANY BACK PROBLEMS? YES / NO _____

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HEALTH SURVEY

1. DO YOU THINK THAT STRESS CAN CAUSE HEALTH PROBLEMS? [ ] YES [ ] NO

2. HAVE YOU HAD ANY STRESS IN THE LAST YEAR? [ ] YES [ ] NO

3. WOULD YOU LIKE TO KNOW THE 7 MAJOR SYMPTOMS OF STRESS SO YOU CAN SEE HOW IT MAY BE AFFECTING YOUR LIFE ? [ ] YES [ ] NO

4. IN THE LAST 30 DAYS HAVE YOU HAD AT LEAST ONE HEADACHE, EVEN IF IT WENT AWAY ON ITS OWN OR WAS MINOR? [ ] YES [ ] NO

5. HOW MANY TIMES HAVE YOU HAD A HEADACHE IN THE LAST 30 DAYS? _____

6. IN THE LAST 30 DAYS HAVE YOU HAD AT LEAST ONE DAY OR PART OF A DAY WHEN YOU LACKED THE ENERGY YOU WOULD HAVE LIKED, OR FELT FATIGUED? [ ] YES [ ] NO

7. WHICH AREA BOTHERS YOU WHEN YOU ARE UNDER TENSION? [ ] PAIN IN THE NECK [ ] SHOULDERS [ ] LOWER BACK

[ ] OTHER _____

8. HOW OFTEN DOES IT OCCUR? _____

9. DO YOU HAVE TROUBLE SLEEPING? [ ] YES [ ] NO

   DO YOU TOSS & TURN, FAIL TO SLEEP THE NIGHT THROUGH? [ ] YES [ ] NO

   DO YOU WAKE UP EARLY? [ ] YES [ ] NO

   DO HAVE TROUBLE FALLING ASLEEP? [ ] YES [ ] NO

   HAS THIS HAPPENED AT LEAST ONCE IN THE PAST MONTH? [ ] YES [ ] NO

10. IN THE LAST MONTH HAVE YOU EXPERIENCED IRRITABILITY OR MOOD SWINGS BEYOND YOUR CONTROL? [ ] YES [ ] NO

11. HAS YOUR DIGESTION OR ELIMINATION BOTHERERED YOU IN ANY WAY IN THE LAST SEVERAL MONTHS? [ ] YES [ ] NO

   DO YOU NEED TO TAKE ANY DIGESTIVE AIDS, LAXATIVES OR AVOID CERTAIN FOODS [ ] YES [ ] NO

   WHAT IS IT THAT BOTHERS YOU? _____

   HOW OFTEN DOES IT BOTHER YOU? _____

12. DO YOU GET ALLERGIES? [ ] YES [ ] NO. DO YOUR SINUSES BOTHER YOU? [ ] YES [ ] NO

   IF YES, HOW OFTEN _____

13. DO YOU HAVE ANY OTHER HEALTH PROBLEMS THAT CURRENTLY BOTHER YOU THAT YOU WISH YOU COULD GET RID OF? [ ] YES [ ] NO

   PLEASE LIST PROBLEMS. _____

14. IF YOU COULD BE RID OF ONE OF THESE SYMPTOMS & NEVER HAVE IT BOTHER YOU AGAIN, WHICH ONE WOULD IT BE?_____

15. IS THIS THE PROBLEM THAT MOST CONCERNS YOU? [ ] YES [ ] NO

16. HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? _____

17. WHAT HAVE YOU HEARD ABOUT CHIROPRACTIC OR CHIROPRACTORS? _____

18. DO YOU KNOW THE DIFFERENCE BETWEEN RELIEF CARE AND CORRECTIVE CARE? [ ] YES [ ] NO

18. IF WE COULD HELP YOU GET RID OF YOUR PROBLEM(S) WOULD YOU LIKE TO DO SO? [ ] YES [ ] NO