

# Chiropractic Patient Information Form Form 1B

Landmark Healthcare, Inc., 1750 Howe Ave., Suite 300, Sacramento, CA 95825

Practitioner Last Name <b>Wagnon</b>	First Name <b>William</b>	M.I. <b>O.</b>	License # <b>14800</b>	Phone # <b>(530) 666-6662</b>	Fax # <b>(530) 666-6643</b>
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**Patient to complete the following sections:**

Patient Last Name	Patient First Name	M.I.	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth (MM/DD/YYYY) / /	
Insured I.D. or SSN	Insured Last Name	M.I.	First Name	Patient Daytime Phone		
Patient Address		City	State	Zip		
Employer Name	Insurance Company	Group Plan # or Union Local				
Is illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Do you have other insurance that might cover this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list other insurance company name:				
Please list your reason(s) for this visit or your condition(s) in order of importance: 1 _____ 2 _____ 3 _____ 4 _____	Date you first noticed: _____ _____ _____ _____	Using a scale in which "0" is <u>none</u> (no pain or symptoms) and "10" is <u>severe</u> pain or symptom(s), <b>circle</b> the number that best reflects your condition: ↓ none . . . . . to . . . . . severe ↓				Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason: <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
		0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%			
		0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%			
		0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%			

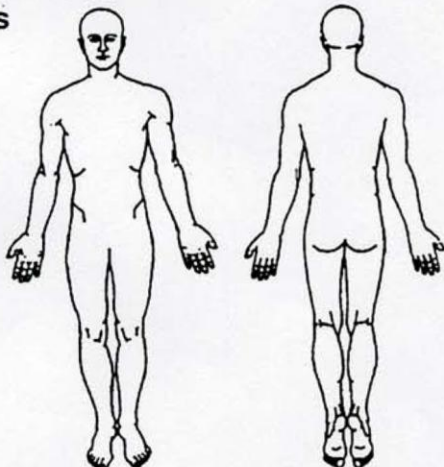
**For each of the reasons or conditions listed above, please mark how it happened:**

- Developed over time Illness Injury Auto accident Other \_\_\_\_\_ I don't know
- Developed over time Illness Injury Auto accident Other \_\_\_\_\_ I don't know
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- Developed over time Illness Injury Auto accident Other \_\_\_\_\_ I don't know

**For each reason listed above, please check if it is better or worse with any of the following:**

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reason 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:**



- +++ Sharp or stabbing
- ooo Pins and needles
- vvv Dull or aching
- /// Numbness

**Please check the box that best describes whether your pain or symptom(s) limit normal activities:**

Activity	Normal	Somewhat limited	Severely limited
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer work/typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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**Please continue ...**

- a. During what time of the day do you feel worse? \_\_\_\_\_
- b. Do you sleep well?  Yes  No What are your normal sleeping hours? \_\_\_\_\_ to \_\_\_\_\_
- c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?  
 No  Yes → For what condition? \_\_\_\_\_  
Name of doctor/provider \_\_\_\_\_ Phone number \_\_\_\_\_
- d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?  
 No  Yes If yes, please describe each event below:  
Event \_\_\_\_\_ Year \_\_\_\_\_  
Event \_\_\_\_\_ Year \_\_\_\_\_
- e. Do you exercise?  Yes  No If yes, please describe activity \_\_\_\_\_  
How many days a week? \_\_\_\_\_ How many minutes per session? \_\_\_\_\_

## Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

### Pain in body

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Neck pain with difficulty swallowing   | <input type="checkbox"/> Recent progressive muscle weakness or shaking  | <input type="checkbox"/> Severe degenerative arthritis                             |
| <input type="checkbox"/> Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck | <input type="checkbox"/> Recent or current fever over 102°F   | <input type="checkbox"/> History of compression fracture                           |
| <input type="checkbox"/> Leg pain that worsens with exercise but is relieved by resting                       | <input type="checkbox"/> Loss of bowel or bladder control   | <input type="checkbox"/> History of heart attack                                   |
| <input type="checkbox"/> Loss of feeling in inner thighs  | <input type="checkbox"/> Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions | <input type="checkbox"/> History of stroke or aneurysm                             |
| <input type="checkbox"/> Back pain with urinary problems  | <input type="checkbox"/> Recent major accident such as a fall from height, whiplash or blow to the head             | <input type="checkbox"/> Past history of cancer or currently diagnosed with cancer |
- Types of pain**
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Severe pain interrupts sleep   | <input type="checkbox"/> Memory loss after injury      | <input type="checkbox"/> Diabetes with cold, burning or numb feet |
| <input type="checkbox"/> Constant pain that doesn't improve by changing positions or lying down | <b>Previously diagnosed condition/ medical history</b> | <input type="checkbox"/> Gout                                     |
- Current conditions**
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Unable to balance when walking | <input type="checkbox"/> Congenital bone or joint disorder | <input type="checkbox"/> Lupus   |
| <input type="checkbox"/> Recent unexplained weight loss | <input type="checkbox"/> Rheumatoid arthritis              | <input type="checkbox"/> Ankylosing spondylitis  |
|   |  | <input type="checkbox"/> Immune suppression such as from chemotherapy, organ transplant, etc.              |
|   |  | <input type="checkbox"/> 3 or more months use of steroid medications or intravenous drugs (past or recent) |

## Family history

- |   |                                   |   |   |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Mental illness   |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizure disorder |

*I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.*

Signature \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_