Welcome to The JosephMethod of Chiropractic

www.marinhealth.com

Date:_____20_____

Last Name_____ **First Name**_____ **Referred by** _____

Mailing Address_____ City _____ St_____ Zip_____ [ ] Male [ ] Female

Home phone _____ Work phone _____ Cell phone _____ Emg phone _____

E-mail Home_____ E-mail Work_____

SSN_____ Date of Birth_____ Age____ Height ___ ft____ in. Weight_____ License_____ State____

Single___ Married___ Divorced___ # children_____ Names /Ages_____

Spouse/Signif. other. (or parent) _____ **Phone**_____ **Cell Phone** _____

Your Employer/Company_____Address_____

City_____ State_____ Zip_____ Occupation _____

Have you ever had chiropractic care before? [ ] Yes [ ] No Do you have insurance? ? [ ]Y [ ] N What company? _____

If you are experiencing any pain (neck pain, mid back pain, low back pain etc.), health problems, symptoms, and/or complaints, please list in order of severity

1._____For how long?_____

2._____For how long?_____

3._____For how long?_____

Currently or in the past have you experienced **any of these complaints while working**? ___ Yes __ No
If yes, please describe what activities at work may be causing you to experience these complaints:_____

[ ] Work Injury in the past? Date_____
Do you have an attorney representing you for this work injury? ___ Yes ___ No If yes, who is your attorney? _____
Other activities, incidents, or events outside of work that may have caused these complaints? _____If yes, please explain:

[ ] Auto Accident in the last 24 months? Date _____
Do you have an attorney representing you for this auto accident? ___ Yes __ No If yes, who is your attorney? _____
How many passengers were in the car with you? _____

Auto Insurance Company Information? _____

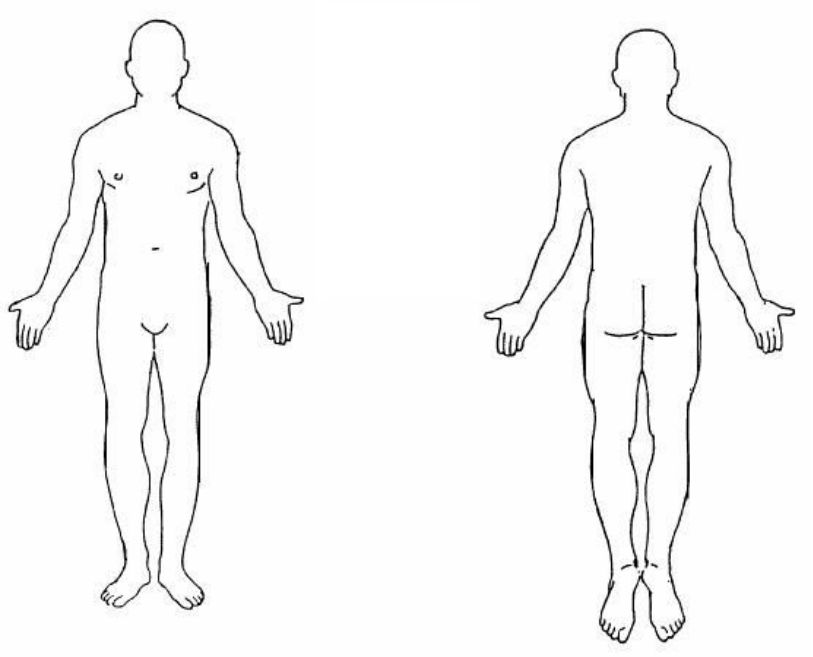
Have you had any **Surgeries or Hospitalizations**? ____ If yes, please list: _____
Please list any current or past injuries and illnesses not listed above: _____

Please check all **Medications** (over the counter and /or prescribed) you are currently taking:
[]Aspirin/Tylenol []Pain Killers []Muscle Relaxers []Birth Control Pills []Sleeping Pills []Anti-Depressants []Others _____

FAX this 2 page form to us 2 days before your appointment. Thanks 415-444-0771

PAIN / SYMPTOM CHART

If you are experiencing symptoms please indicate on the figures.



FUNCTION SCALE: How are you impacted by your condition?
Please circle the numbers from 0 to 10, where 10 is the worst.

0 is Perfect -- 10 is a complete loss of function.

	Rating
Family Home Responsibilities: Activities related to the home or family (i.e. chores, yard work, driving, etc.).	**0 1 2 3 4 5 6 7 8 9 10**
Recreation: Hobbies, sports, and other similar leisure time activities.	**0 1 2 3 4 5 6 7 8 9 10**
Social Activity: Activities which involve friends and acquaintances (i.e. dining out, parties, movies, etc.)	**0 1 2 3 4 5 6 7 8 9 10**
Occupation: Job activities I(i.e. homemaker responsibilities, keyboarding, repetitive motions, etc.)	**0 1 2 3 4 5 6 7 8 9 10**
Self Care: Personal maintenance and independent daily living (grooming, dressing, etc.).	**0 1 2 3 4 5 6 7 8 9 10**
Life Support Activity: Basic life supporting behaviors such as eating, sleeping, and breathing.	**0 1 2 3 4 5 6 7 8 9 10**

I will be paying by: [ ] CASH [ ] CHECK [ ] VISA/MC [ ] _____

NOTICE: NOT ALL PATIENTS REQUIRE XRAYS TO DETERMINE TYPE OF CARE OR LENGTH OF CARE.

Our radiology department is digital, so for your convenience we may burn a copy of your imaging study to CD. ($20 fee)

All office visit charges are payable when services are rendered, unless otherwise arranged. Thank You.
Our purpose is first and foremost to help you get well and help is available with finances if needed.

Patient/Parent/Guardian **x**_____ **date**_____

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