Office of Dr. Elena Esparza, D.C.

Confidential Patient Information

Name_____ Today's Date: _____

Date of Birth_____ Age_____ Gender M or F Marital Status_____ # Children____

Address_____
Address *City* *State* *Zip Code*

Home Phone #_____ Cell Phone_____ Email_____

_____
Your Occupation *Company Name* *City* *Work Phone*

_____
Spouse or Guardian's Name *Occupation* *Company Name* *City*

How did you hear about us?_____

Do you have health insurance? □Yes □No Company_____ ID# or SS# _____

If yes, please present your card(s) to the office manager for processing.

PERSONAL HEALTH 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.

GENERAL CURRENT CONDITIONS

Recent accident such as a fall, whiplash, or blow to the head
- ☐ Muscle spasms
- ☐ Numbness or tingling of hands or feet or radiating pain
- ☐ Headaches
- ☐ Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Dizziness
- ☐ Vision problem
- ☐ Nausea
- ☐ Restriction of movement
- ☐ Sleeping trouble
- ☐ Asthma or breathing problem
- ☐ High blood pressure
- ☐ Hearing problem
- ☐ Convulsions/epilepsy
- ☐ Heartburn/Acid Reflux
- ☐ Digestive trouble
- ☐ Menstrual problems
- ☐ Sinus problems
- ☐ Difficulty with stress
- ☐ Spinal disorder
- ☐ Shoulder, arm or hand problem
- ☐ Hip, Leg or foot problem
- ☐ Jaw/mouth problem
- ☐ Constipation

DIAGNOSED CONDTIONS
- ☐ Born with bone or joint disorder
- ☐ Degenerative arthritis
- ☐ Rheumatoid arthritis
- ☐ Compression fracture
- ☐ Heart attack or heart disorder
- ☐ History of stroke or aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- ☐ 3 or more months of steroid medications or intravenous drugs (past or present)
- ☐ Tuberculosis
- ☐ Hepatitis B or HIV infection
- ☐ Multiple sclerosis
- ☐ Thyroid or hormone disorder

OTHER CONDITIONS/ Diagnosis
- ☐ _____
- ☐ _____
- ☐ Drink _____
- ☐ Smoke _____

SPECIFIC PAIN IN THE BODY
- ☐ Neck pain with difficulty swallowing
- ☐ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ☐ Leg pain that worsens with exercise
- ☐ Numbness of inner thighs
- ☐ Back pain with urinary problems
- ☐ Severe pain that interrupts sleep
- ☐ Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS
- ☐ Poor balance when walking or standing
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ Memory loss after injury
- ☐ Recent, unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking
- ☐ Recent or current fever over 102°F
- ☐ Loss of bowel or bladder control

-Please Continue on Page 2-

B/M / Day _____ *Fruit* _____ *Hours of sleep* _____
H2O/Day _____ *Protein* _____ *Exercise/ wk* _____
*Veggies*_____ *Oils* _____ *Meals/day* _____

(Confidential Patient Information Continued)

Name:_____ Date:_____

BRIEFLY DESCRIBE YOUR HEALTH ISSUE(S) or CONCERNS:

_____

_____

_____

_____

When did it start? _____

What caused it? _____

What makes it better? _____

What makes it worse? _____

What percentage of each day does it currently bother you? (Circle one)

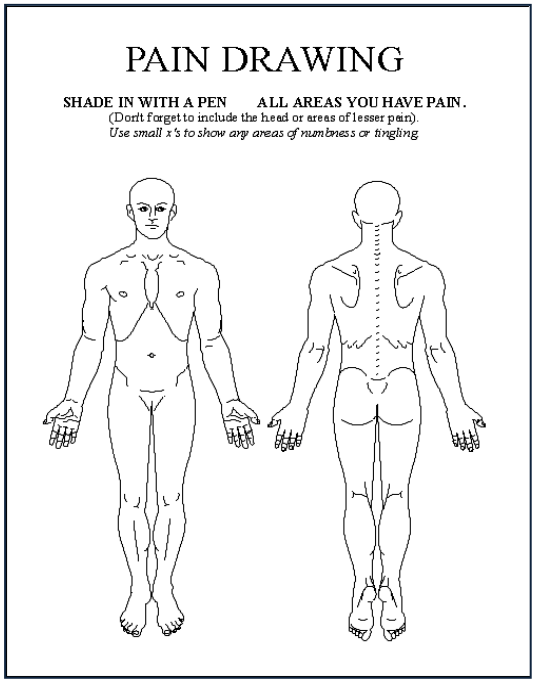
0% 25% 50% 75% 100%

What would you like to do but can't because of the pain?

_____

List other health care professionals you have seen for this condition.

_____



Please circle a number for the pain level that most represents your pain for EACH body area of concern: 0 1 2 3 4 5 6 7 8 9 10 *Right now*

No pain |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____| Unbearable

FAMILY HISTORY (Circle) Spine problems Autoimmune disorders Arthritis Cancer Diabetes Heart disease Kidney disease Mental illness Seizures Other:_____

NOTE For whom: F= Father, M= Mother, GF= Grandfather, GM= Grandmother, ect.

Last known: Height_____ Weight_____ **Are you pregnant?** □Yes □No Date of Last Period_____

Describe any **surgeries** or hospitalizations you've had and the dates_____

_____

Allergies? _____

Drink? _____ If yes, how much? _____ Smoke?_____ If yes, how much?_____

Current Medications/ Supplements:_____

_____

Personal Medical Physician_____ Phone _____

How would you rate your diet?_____ What kind of exercise do you do weekly?_____

What do you do to mentally de-stress?_____

Do you feel you have a pretty good understanding of what CHIROPRACTIC is and how we treat? □Yes □Maybe □No

Have you ever been under a doctor's care before? □ No □Yes-Describe:_____

What is your goal or any intentions you would like to see happen for you in this visit?_____

_____

_____

Patient Signature: _____ Date: _____

Attending Doctor: _____ Date: _____