SAN DIEGO SPINAL CARE
NUCCA CHIROPRACTIC CARE

6370 LUSK BLVD. STE. F205, SAN DIEGO, CA
WWW.SDSPINALCARE.COM
(858) 877-3217

CONFIDENTIAL HEALTH RECORD

Welcome To Our Office!

Today's Date M/D/Y ___/___/___

Whom may we thank for referring you to our office? PLEASE CHECK & COMPLETE.

○ Family _____ ○ Friend _____ ○ Co-Worker _____

○ Internet/Website _____ ○ Other _____

PERSONAL INFORMATION

Name LAST _____ FIRST _____ MIDDLE _____

Birth Date M/D/Y ___/___/___ Age _____ Sex PLEASE CHECK ○ Male ○ Female Social Security # ___-___-___

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone # HOME _____ CELL _____ WORK _____

Email Address _____

Marital Status PLEASE CHECK ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated

Spouses Name LAST _____ FIRST _____

EMERGENCY CONTACT

Name LAST _____ FIRST _____ Relationship ○ Spouse ○ Relative ○ Friend

Phone # HOME _____ CELL _____ WORK _____

EMPLOYMENT INFORMATION

Business Name _____

City _____ State _____ Zip _____

Phone # _____

PRESENT HEALTH CHALLENGE

IF YOU HAVE NO SYMPTOMS OR COMPLAINTS, AND ARE HERE FOR **CHIROPRACTIC WELLNESS SERVICES**, CHECK HERE ○

UNWANTED HEALTH CHALLENGE

Explain why you are here today _____

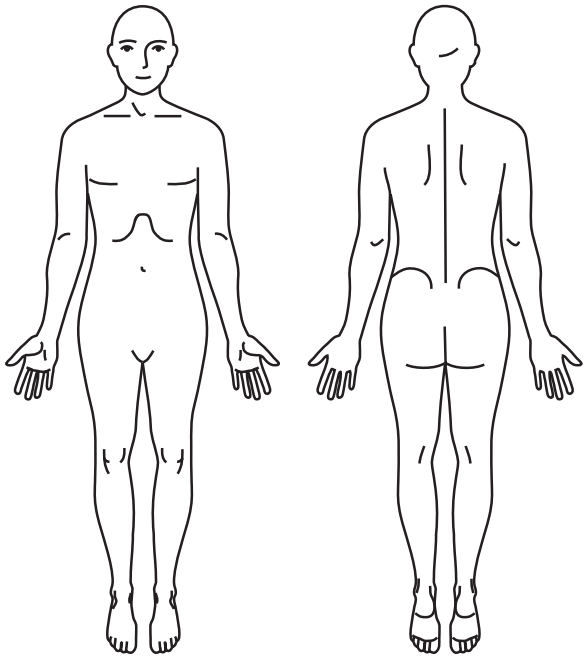
When did this begin? M/D/Y ___/___/___

Has it ever occurred before? ○ Yes ○ No

When do you think these problems originally started? _____

Date of Auto Crash or Work Related Injury M/D/Y ___/___/___

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



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CONFIDENTIAL HEALTH RECORD 2/4

PLEASE CHECK THE APPROPRIATE CIRCLE & COMPLETE BLANKS.

Body Area(s) Involved ○ Neck ○ Back ○ Head ○ Other _____

Mechanism of Onset ○ Auto ○ Work ○ Slip/Fall ○ Lifting ○ Slept Wrong ○ Repetitive Motion
○ Other _____

Current Symptoms ○ Pain ○ Numbness ○ Stiffness ○ Weakness ○ Other _____

Quality ○ Burning ○ Diffuse ○ Dull/Aching ○ Localized ○ Radiating ○ Sharp ○ Shooting
○ Stabbing ○ Throbbing ○ Tightness ○ Tingling ○ Other _____

Timing ○ Morning ○ Afternoon ○ Night ○ With Activity ○ Constant ○ Intermittent

What makes it Worse? _____

What Makes it Better? _____

Level of Impairment Due to Symptoms CIRCLE THE APPROPRIATE LEVEL WITH **0 = NONE / 10 = EXTREME**

While Resting	0	1	2	3	4	5	6	7	8	9	10
With Activity	0	1	2	3	4	5	6	7	8	9	10

Headaches
Location ○ Occipital ○ Frontal ○ Left Temporal ○ Right Temporal ○ Parietal ○ Sinus
Quality ○ Dull ○ Sharp ○ Throbbing ○ Stabbing ○ Aura ○ No Aura
Types ○ Hat Band ○ Cluster ○ Migraine ○ Tension

Employment – Occupation/Job Title _____ Work # _____ hours per day

Repetitive Activities ○ Lifting ○ Computer ○ Grasping ○ Hand Tools ○ Machinery ○ Phone

Conditions Effect on Job Performance ○ No Effect ○ Mild Pain ○ Moderate Pain ○ Unable to Perform

Daily Activities – Effects of Current Condition on Performance

Bending	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Carrying Groceries	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Change Position (Sit-Stand)	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Climb Stairs	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Driving	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Extended Computer Use	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Household Chores	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Kneeling	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Lifting	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Pet Care	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Reading/Concentration	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Self Care (Bathe/Dress)	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Sexual Activities	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Sleep	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Prolonged Sitting	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Prolonged Standing	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Walking	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Yard Work	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)

Recreational Activities – PLEASE LIST ANY CURRENT RECREATIONAL ACTIVITIES AND THE EFFECTS OF CURRENT CONDITION ON PERFORMANCE

_____	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
_____	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)

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CONFIDENTIAL HEALTH RECORD 3/4

LIFESTYLE REVIEW

1. Do you believe that it is possible for your body to heal? ○ Yes ○ No
2. Have you received chiropractic services in the past? ○ Yes ○ No
3. What Wellness services/products do you currently incorporate into your lifestyle? _____
4. What Supplements are you currently taking? _____
5. On a scale of 1-10 describe your stress level **1 = NONE / 10 = EXTREME** Occupational _____ Personal _____
6. On a scale of Poor, Good, Excellent please describe your lifestyle MARK **POOR**, **GOOD** OR **EXCELLENT**.

Diet _____ Exercise _____ Sleep _____ General Health _____

REVIEW OF SYSTEMS

PLEASE CHECK THE BOXES BELOW THAT APPLY TO YOU. IF NONE OF THEM APPLY, PLEASE CHECK THE **I DENY** BOX IN THE SHADED AREA.

Nervous System

- ○ I DENY having Any of the Symptoms or Problems Listed Below.
- ○ Dizziness ○ Seizures ○ Loss of Memory ○ Slurred Speech ○ Loss Of Consciousness
- ○ Strokes ○ Tremor ○ Limb Weakness ○ Facial Weakness ○ Sleep Disturbance
- ○ Stress ○ Numbness ○ Headache ○ Loss of Balance ○ Tinnitus/Ringing in Ears

Constitutional

- ○ I DENY having Any of the Symptoms or Problems Listed Below.
- ○ Chills ○ Fatigue ○ Night Sweats ○ Daytime Drowsiness
- ○ Fever ○ Weight Loss ○ Weight Gain

Respiration

- ○ I DENY having Any of the Symptoms or Problems Listed Below.
- ○ Asthma ○ Coughing up Blood ○ Sputum Production
- ○ Cough ○ Shortness of Breath ○ Wheezing

Cardiovascular

- ○ I DENY having Any of the Symptoms or Problems Listed Below.
- ○ Ulcers ○ Heart Murmur ○ High Blood Pressure ○ Orthopnea (Difficulty Breathing Lying Down)
- ○ Chest Pain ○ Swelling Of Legs ○ Low Blood Pressure ○ Claudication (Leg Pain/Ache)
- ○ Palpitations ○ Varicose Veins ○ Shortness Of Breath ○ Angina (Chest Pain or Discomfort)

Gastrointestinal

- ○ I DENY having Any of the Symptoms or Problems Listed Below.
- ○ Diarrhea ○ Indigestion ○ Abnormal Stool ○ Vomiting Blood ○ Abnormal Stool Color
- ○ Belching ○ Vomiting ○ Abdominal Pain ○ Black - Tarry Stools
- ○ Nausea ○ Heartburn ○ Hemorrhoids ○ Difficulty Swallowing
- ○ Jaundice ○ Constipation ○ Rectal Bleeding ○ Abnormal Stool Consistency

Psychologic

- ○ I DENY having Any of the Symptoms or Problems Listed Below.
- ○ Irritability ○ Convulsions ○ Memory Loss ○ Behavioral Change
- ○ Anxiety ○ Depression ○ Mood Change ○ Loss or Change in Appetite
- ○ Confusion ○ Insomnia ○ Bi-Polar Disorder

Allergy

- ○ I DENY having Any of the Symptoms or Problems Listed Below.
- ○ Itching ○ Anaphalaxis ○ Food Intolerance ○ Nasal Congestion ○ Rash

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CONFIDENTIAL HEALTH RECORD 4/4

HEALTH HISTORY

FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.

Previous Chiropractic Care: ○ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name _____ Date of Last Visit M/D/Y ___/___/___

Current Medication(s) LIST **ANY/ALL** MEDICATIONS YOU ARE **CURRENTLY** TAKING. BE SPECIFIC. _____

_____

_____

Doctor's Name _____

Childhood illness(es) **LIST** ALL HEALTH CONDITIONS. _____

Adult illness(es) **LIST** ALL HEALTH CONDITIONS. _____

_____

Surgery(ies) **LIST** ALL SURGICAL PROCEDURES. WRITE THE **DATE** OF THE PROCEDURE IMMEDIATELY AFTERWARD. _____

_____

_____

Injury(ies) MARK OR LIST ALL INJURIES. WRITE THE **DATE** OF THE INJURY IMMEDIATELY AFTERWARD.

- ○ Back Injury M/D/Y ___/___/___
- ○ Broken Bones M/D/Y ___/___/___
- ○ Laceration (Severe) M/D/Y ___/___/___
- ○ Fracture M/D/Y ___/___/___
- ○ Head Injury M/D/Y ___/___/___
- ○ Loss Of Consciousness M/D/Y ___/___/___
- ○ Disability M/D/Y ___/___/___
- ○ Joint Injury M/D/Y ___/___/___
- ○ Motor Vehicular Crash M/D/Y ___/___/___
- ○ Fall (Severe) M/D/Y ___/___/___

SOCIAL HISTORY

MARK ALL THAT APPLY BELOW.

Tobacco ○ Do not use tobacco ○ Smoke/Chew: # _____ per Day ○ Live with a smoker ○ Quit smoking

Alcohol ○ Do not use alcohol ○ # _____ Drinks per Week ○ # _____ Drinks per Month

An evaluation will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation and radiological examination (x-rays).

The statements made on this form are accurate to the best of my recollection and I knowingly allow San Diego Spinal Care to examine me for further evaluation.

Signature _____ **Date** M/D/Y ___/___/___