Torrey Hills Chiropractic ~ Dr. Steve Ronco

4653 Carmel Mountain Road, Suite 303, San Diego, CA 92130 858-481-1422

Name _____ What do you preferred to be called? _____

Street Address _____

City _____ State _____ Zip _____ Email _____

Phone: Home _____ Work _____ Cell _____

Date of Birth _____ SS# _____ - _____ - _____ Occupation _____

Employer _____ Street Address _____

City _____ State _____ Zip _____ Spouse's Name _____

How did you hear about us? _____

Please Check One: Sex: ☐Male ☐Female ☐Married ☐Single ☐Divorced ☐Widowed

Health History:

Describe the purpose of this visit _____

_____

Is the purpose of this appt. related to: ☐Job ☐Sports ☐Auto ☐Fall ☐Chronic Discomfort ☐Other

Describe any current health problems, including how long you have had them _____

_____

Are you under the care of any other doctor? ☐Yes ☐No

If Yes, the conditions being treated for: _____

List any current medications _____

List any past surgeries & dates _____

List any past accidents & dates _____

List any x-rays you've had taken in the past 2 years _____

Personal & Family History:

Significant others health status _____

Children's ages & health status _____

Chiropractic History & Your Health Objectives:

Have you ever been to a Chiropractor before? ☐Yes ☐No If Yes, Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care _____

Are other family members under chiropractic care? ☐Yes ☐No Who? _____

In addition to the main reason for today's visit, what additional health objectives do you have for your future?

_____

_____

Have you ever been to another doctor who has put you on a Wellness Program? ☐Yes ☐No

If yes, Who? _____ ☐MD ☐DC ☐Other _____

What were the results? _____

Were the results permanent? ☐Yes ☐No ☐Don't Know

Are you as healthy today or healthier than you were 5 years ago? ☐Yes ☐No ☐Don't Know

If you had been put on a Wellness Program in the past, what strategies have you continued to use? _____

_____

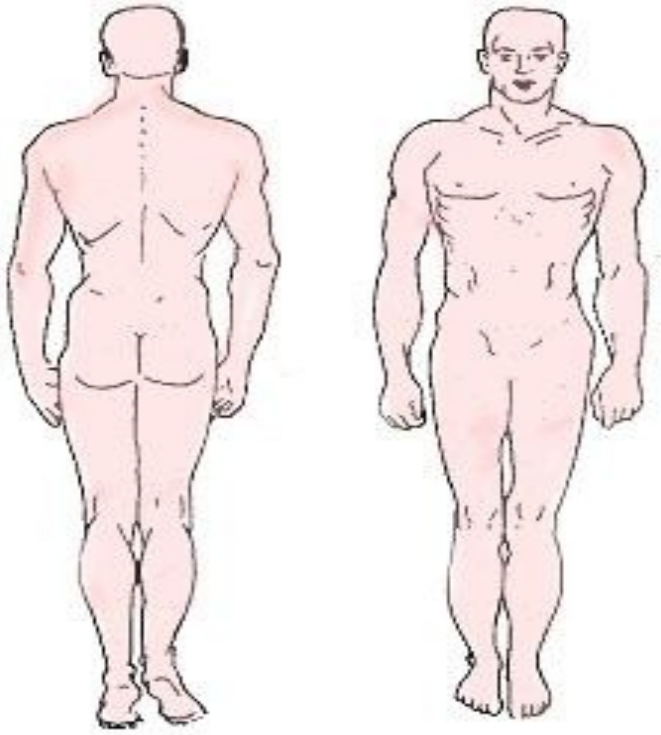
Do you feel you will stay as healthy as you are today 5 years from now? ☐Yes ☐No ☐Don't Know

If yes, what strategies will you implement to get there? _____

If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache/Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Earaches/Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Insurance: *(please provide office with a copy of your insurance card)*

Insurance Co. Name _____ Group # (Plan, Local, Policy #) _____

Address _____ Phone _____

Name of Insured Person _____ Insured's SS# _____

Relation to Insured _____ Insured's Date of Birth _____

Insured's Employer _____

Emergency Contact:

Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

I acknowledge that all information given on this form and to the Doctor is true and accurate. I hereby aughorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature _____ Date _____