

Torrey Hills Chiropractic ~ Dr. Steve Ronco

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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? _____

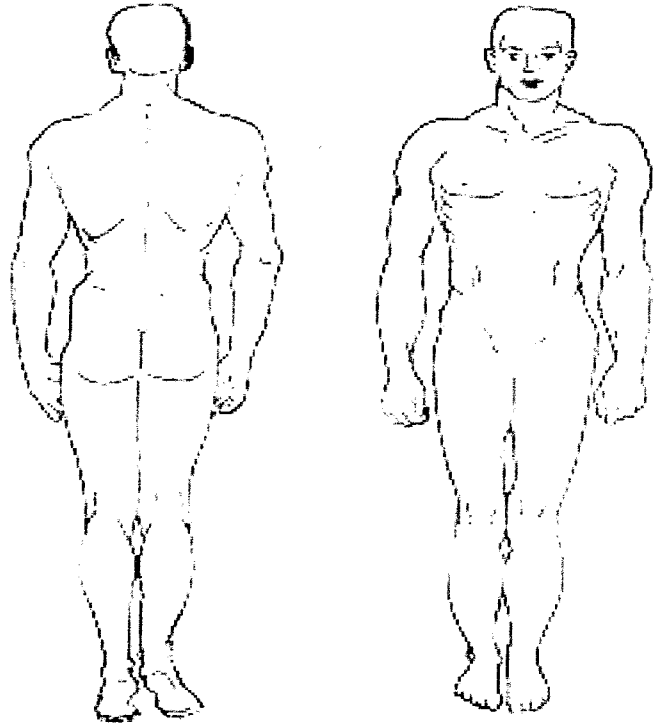
Do you feel you will stay as healthy as you are today 5 years from now? Yes No Don't Know

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	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Earaches/Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

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 authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature _____ Date _____