Dr. Timothy R. Campbell, D.C.
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Sherman Oaks, CA 91403
818-783-5025

OFFICE POLICIES and DIRECTIONS

Directions: We are located off the Ventura (101) Freeway, Exit on Van Nuys Blvd., go South and we are on the Southwest corner of Moorpark Street and Van Nuys Blvd. We are located in what is commonly known as the "Hamburger Hamlet Building". There is parking directly behind the building, and we do not validate. There is also metered parking on the street.

Office Hours by appointment:
Monday, Tuesday, Wednesday, Friday- 8:30 AM to 12 Noon, 2:00 PM to 6:00 PM
Thursday - Closed
Saturday - 8:30 AM - 12:00 Noon
Sunday - Closed

Cancellation Fee: Unlike some medical treatments, chiropractic requires a specific amount of time, thereby limiting the number of patients that can be treated in a day. Every effort is made to fill all cancelled appointments, however, we have a better opportunity to do that with 24-hours notice. Therefore, the patient is responsible for any unfilled appointment that has been cancelled with less than 24-hours notice. YOU WILL BE CHARGED A CANCELLATION FEE EQUAL TO THE AMOUNT OF THE SERVICE SCHEDULED -- A BROKEN APPOINTMENT FEE.

Please be aware that our office is closed on Thursdays and Sundays and that we DO NOT retrieve any messages from the answering machine until the next working day. Missed appointments made for a Monday or a Friday when the notice of cancellation is left on our voice mail and retrieved on the appointed Monday or Friday, makes the patient responsible for a charge equal to the amount of the appointed time scheduled.

Late Arrivals: When scheduling your appointments, we try to accommodate the needs of all our patients. We would truly appreciate it if you could be considerate of the needs of our other patients by arriving at your scheduled time. Thank you.

Insurance & Payment Policies: We request payment at the time of service, and we will provide you with a superbill with all the pertinent information needed to forward to your insurance company for reimbursement. We are not a provider for any insurance company or policy, and we do not do any insurance billing or Medicare billing.

You may pay for your visit by cash, check, debit, or credit card (Visa or MasterCard.)
There is a $2.00 charge for any credit card payment transaction.

REQUIRED FOR YOUR CASE HISTORY FILE

File #_____ Date_____

Name_____

Address_____City_____State_____Zip_____

Telephone_____Social Security_____Drivers Lic#_____
Age_____Birthdate_____ Sex_____Marital Status M S W D No. Of Children_____
Occupation_____Employer_____Years Employed_____
Employer's Address_____City _____State_____Work Phone_____
Spouse's Name_____Occupation_____Employer_____
Person responsible for account_____Referred by:_____

Weight_____pounds, Height_____ft. _____inches

Present Complaints - Please check all answers and fill in the blanks where appropriate:
What is your major complaint?_____

Other Complaints?_____
List surgical operations and years:_____

OTHER DOCTOR SEEN FOR THIS CONDITION: M.D.__D.C.__D.D.S___D.O.__L.Ac.__O.M.D.____
Doctor's Name_____Diagnosis:_____
X-rays_____Urinalysis_____Blood Tests_____Other_____
Treatment: Medication_____
Non-prescription drugs -what kind?_____
Traction_____Physiotherapy_____Shots_____Surgery_____
Results_____
Length of time under his care _____Other/None_____
Were you off work?____ If so, how long?_____Have you returned to your same job?_____
If not why?_____

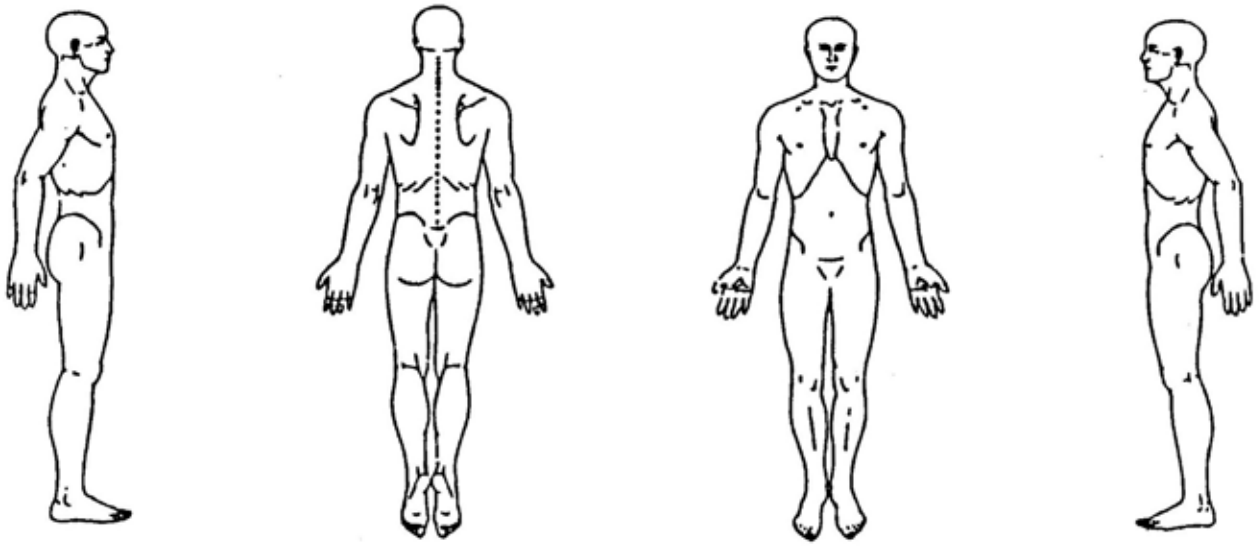
I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's
Signature:_____Date_____

PRESENT COMPLAINTS

1. Please describe the character of your current pain (you may check one or more answers):
   Weakness__ Throbbing/Gnawing__ Numbness__ Shooting__ Gripping/Constricting___
   Burning__ Tingling__
2. How often are the complaints present? Constant (76-100%)__ Frequent (51-75%):___
   Occasional (26-50%):___ Intermittent (25% or less):___
3. How bad is your pain or ache? Please circle a number:
   0 1 2 3 4 5 6 7 8 9 10 (0=no pain, 10=unbearable pain)
4. Since your problem began is the pain: Increasing____ Decreasing____ Not changing____
5. When did your problem begin - specific date if possible_____
6. Did your problem begin: Immediately after a specific incident___ Multiple incidents____
   Gradually developed over time___ No specific reason___
7. Describe how your problem began:_____
   _____
8. What makes your problem better? Nothing___ Lying down____ Walking____ Standing___
   Sitting____ Movement/Exercise____ Inactivity____
9. What makes your problem worse? Nothing____Lying down____ Walking____ Standing___
   Sitting____ Movement/Exercise_____ Inactivity____
10. How would you grade your general stress level? No stress_____ Minimal stress_____
    Moderately stressed_____ Greatly stressed_____
11. Physical activity at work: Sitting more than 50% of workday_____ Light manual labor_____
    Manual labor_____ Heavy manual labor_____
12. General physical activity: No regular exercise program_____ Light exercise program_____
    Strenuous exercise program_____
13. Are your complaints affecting your ability to work or otherwise be active?
    No effect_____ Need limited assistance with common everyday tasks_____
    Have a significant inability to function without assistance_____ Need assistance often_____
    Some physical restrictions (able to perform light duty & household tasks) _____
    Am totally disabled (impaired). Cannot care for self_____ Interferes with sleep_____

MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS, INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patients Signature:_____ Date_____

If you have ever had a listed symptom in the <u>past</u>, please check that symptom in the <u>past</u> column. If you are <u>presently</u> troubled by a particular symptom, check the <u>present</u> column.

Past	Present	Conditions
____	____	Aortic Aneurysm
____	____	High Blood Pressure
____	____	Angina
____	____	Heart Attack
____	____	Stroke
____	____	Asthma
____	____	Cancer
____	____	Anorexia
____	____	Blood Disorder
____	____	Emphysema
____	____	Arthritis
____	____	Ulcer
____	____	Kidney Stones
____	____	Kidney Disorders
____	____	Colitis
____	____	Irritable Bowel
____	____	HIV/AIDS

HEAD

____	____	Headache
		sinus (allergy)___
		entire head ___
		back of head ___
		forehead ___
		temples ___
		migrane ____
____	___	Head feels heavy
____	____	Loss of memory
____	____	Light-headedness
____	____	Fainting
____	____	Lights bother eyes
____	____	Blurred vision
____	____	Double vision
____	____	Loss of smell
____	____	Loss of taste
____	____	Loss of balance
____	____	Dizziness
____	____	Loss of hearing
____	____	Pain in ears
____	____	Ringing in ears

NECK

____	____	Pain in neck
____	____	Neck pain with movement
		forward ___
		backward ___
		turn left or right ___
		bend to left or right ___

Past	Present	Condition
____	____	Pinched nerve in neck
____	____	Neck feels out of place
____	____	Muscle spasms
____	____	Grating sound in neck
____	____	Popping sound in neck
____	____	Arthritis in neck

SHOULDERS

____	____	Pain in shoulder joint (R-L)
____	____	Pain across shoulders
____	____	Bursitis (R-L)
____	____	Arthritis (R-L)
____	____	Can't raise arm
		Above shoulder level____
		Over head____
____	____	Tension in shoulders
____	____	Pinched nerve in shoulder (R-L)
____	____	Muscle spasms in shoulders

MID-BACK

____	____	Mid-back pain
____	____	Pain between shoulder blades
____	____	Sharp stabbing
____	____	Dull ache
____	____	Pain from front to back
____	____	Muscle spasms
____	____	Pain in kidney area

CHEST

____	____	Chest pain
____	____	Shortness of breath
____	____	Pain around ribs
____	____	Breast pain
____	____	Dimpled or orange peel breast
____	____	Irregular heartbeat

ABDOMEN

____	____	Nervous stomach
____	____	Foods can't eat_____
		_____
____	____	Nausea
____	____	Gas
____	____	Constipation
____	____	Diarrhea
____	____	Hemorrhoids
____	____	Abdominal pain

ARMS & HANDS

____	____	Pain in upper arm
____	____	Pain in elbow
____	____	Movement aggravated
____	____	Tennis elbow
____	____	Pain in forearm

Past Present Condition

____ ____ Pain in hands
____ ____ Pain in fingers
____ ____ Sensation of pin/needles in arms
____ ____ Sensation of pin/needles in fingers
____ ____ Numbness in arms or forearms (R-L)
____ ____ Numbness in fingers or hands
____ ____ Hands cold
____ ____ Swollen or sore joints in fingers
____ ____ Arthritis in fingers
____ ____ Loss of grip strength

WOMEN ONLY

____ ____ Menstrual pain_____(where)
____ ____ Cramping
____ ____ Irregularity
____ ____ Cycle_____days
____ ____ Birth Control_____(type)
____ ____ Hysterectomy
____ ____ Salpingo-oophorectomy
____ ____ Genital Cancer
____ ____ Discharge
____ ____ Tumors
____ ____ Abortions
____ ____ Menopausal
____ ____ Post-Menopausal
____ ____ Last Menstrual Period
____ ____ Breast soreness/lumps
____ ____ PMS
____ ____ Loss of bladder control
____ ____ Painful urination
____ ____ Pregnancy

MEN ONLY

____ ____ Urinary Frequency
____ ____ Difficulty in starting
____ ____ Dribbling
____ ____ Night Urination
____ ____ Prostate pain/swelling

LOW BACK

____ ____ Low Back Pain
____ ____ Upper Lumbar
____ ____ Lower Lumbar
____ ____ Sacro-iliac
____ ____ Low Back pain is worse when:
____ ____ Lifting
____ ____ Stooping
____ ____ Standing
____ ____ Sitting
____ ____ Bending
____ ____ Coughing
____ ____ Lying down (sleeping)
____ ____ Walking
____ ____ Pain relieves when_____
____ ____ Slipped disc

Past Present Condition

____ ____ Low back feels out of place
____ ____ Muscle spasms
____ ____ Arthritis

HIPS, LEGS, FEET

____ ____ Pain in buttocks (R-L)
____ ____ Pain in hip joint (R-L)
____ ____ Pain down leg (R-L)
____ ____ Pain down both legs
____ ____ Knee pain
____ ____ Inside
____ ____ Outside
____ ____ Leg Cramps
____ ____ Cramps in feet (R-L)
____ ____ Pin/needles in legs (R-L)
____ ____ Numbness of leg (R-L)
____ ____ Numbness of feet (R-L)
____ ____ Numbness of toes
____ ____ Feet feel cold
____ ____ Swollen ankles (R-L)
____ ____ Swollen feet (R-L)
____ ____ Pain in ankle or foot

GENERAL

____ ____ Nervousness
____ ____ Irritable
____ ____ Depressed
____ ____ Fatigue
____ ____ Generally feel run-down
____ ____ Normally sleep_____hrs/night
____ ____ Loss of sleep_____hrs/night
____ ____ Loss of weight _____lbs.
____ ____ Gain weight_____lbs.
____ ____ Coffee_____cups/day
____ ____ Tea_____cups/day
____ ____ Alcohol use
____ ____ Cigarettes_____pack/day
____ ____ Diabetes
____ ____ Hypoglycemia
____ ____ Jaw Pain
____ ____ Convulsions
____ ____ Muscular incoordination
____ ____ Excessive thirst
____ ____ Chronic cough
____ ____ Difficulty swallowing
____ ____ Dermatitis/Eczema/Rash
____ ____ Alcohol/drug dependency
____ ____ Tinnitus (ear noises)
____ ____ Other

BALANCING BODY CHEMISTRY *HEALTH ASSESSMENT*

Balancing Body Chemistry

Name: _____ Sex: ____ Age: ____ Date: _____

Patient's Health Professional: _____

PART I

Circle any of the following medications you are taking:

- Antacids
- Antibiotic/Antifungal
- Antidepressants
- Antidiabetic/Insulin
- Aspirin/Tylenol
- Chemotherapy
- Cortisone Anti-Inflammatories
- Diuretics
- Heart Medications
- High Blood Pressure
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Radiation
- Relaxants/Sleeping Pills
- Recreational Drugs Specify _____
- Thyroid
- Ulcer Medications
- Other _____

Circle if you eat, drink, or use:

- Alcohol
- Candy
- Carbonated Beverages
- Cigarettes
- Coffee
- Distilled Water
- Fluoridated/Chlorinated Water
- At fast food restaurants regularly
- Fried Foods
- Refined (White) Flour Products
- Luncheon Meats
- Margarine
- Refined Sugars
- Milk Products
- Artificial Sweetners
- Non-Herbal Teas
- Chew Tobacco
- Vitamins & Minerals
- Specify _____

Circle if you:

- Diet often
- Salt food without tasting
- Exercise less than 3 times weekly
- Are under excessive stress
- Are exposed to chemicals at work
- Are exposed to cigarette smoke

DIRECTIONS: **Please read each description and darken the number which best describes the frequency of your symptoms within the past year. If you do not understand a symptom, put a (?) *before* the symptom's number.**

KEY: **0 = Never** **1 = Mild** (Occurs once a month or less) **2 = Moderate** (Occurs several times monthly) **3 = Severe** (Aware of it almost constantly)

PART II

IMPORTANT

Dear Patient, Please list your five major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART III

CATEGORY I

Section A:

1. Bad breath, halitosis	0	1	2	3
2. Loss of taste for high protein foods (meat, etc.)	0	1	2	3
3. Burning ("acid") or nervous stomach, eating relieves	0	1	2	3
4. Gas shortly after eating	0	1	2	3
5. Indigestion 1/2 to 1 hour after eating, may last 3-4 hours	0	1	2	3
6. Difficulty digesting fruits or vegetables; undigested foods found in stools	0	1	2	3
7. Acid or spicy foods upset stomach	0	1	2	3

Section B:

8. Lower bowel gas and or bloating several hours after eating	0	1	2	3
9. Feet burn	0	1	2	3
10. "Whites" of eyes (sclera) yellow	0	1	2	3
11. Dry skin, itchy feet and/or skin peels on feet	0	1	2	3
12. Brown spots or bronzing of skin	0	1	2	3
13. Bitter metallic taste in mouth	0	1	2	3
14. Blurred vision	0	1	2	3
15. Headache over eyes	0	1	2	3
16. Feel nauseous, queasy or gag easily	0	1	2	3
17. Color of stools light brown or yellow	0	1	2	3
18. Greasy or high fat foods cause distress	0	1	2	3
19. Pain between shoulder blades	0	1	2	3
20. Dark circles under eyes	0	1	2	3
21. "Acid" breath	0	1	2	3
22. History of gallbladder attacks or gallstones OR gallbladder removed	YES		NO	
23. Appetite reduced	0	1	2	3

Section C:

24. Coated tongue or "fuzzy" debris on tongue	0	1	2	3
25. Pass large amounts of foul smelling gas	0	1	2	3
26. Irritable bowel or mucous colitis	0	1	2	3
27. Constipation, diarrhea alternating or stools alternate from soft to watery	0	1	2	3
28. Bowel movements painful or difficult, constipation, and/or laxatives used	0	1	2	3
29. Burning or itching anus	0	1	2	3

CATEGORY II:

30. Head congestion/"sinus fullness:	0	1	2	3
31. Sneezing attacks	0	1	2	3
32. Dreaming, nightmare-like bad dreams	0	1	2	3
33. Milk products and/or wheat products cause distress	0	1	2	3
34. Eyes and nose watery	0	1	2	3
35. Eyes swollen and puffy	0	1	2	3
35. Pulse speeds after meals and/or heart pounds after retiring	0	1	2	3

CATEGORY III:

Section A:

37. Crave sweets or coffee in afternoon or	0	1	2	3
mid-morning	0	1	2	3
38. Hungry between meals or excessive appetite	0	1	2	3
39. Overeating sweets upsets	0	1	2	3
40. Eat when nervous	0	1	2	3
41. Irritable before meals	0	1	2	3
42. Get "shaky" or light-headed if meals delay	0	1	2	3
43. Fatigue, eating relieves	0	1	2	3
44. Heart palpitates if meals missed or delayed	0	1	2	3
45. Awaken a few hours after sleep, hard to get back to sleep	0	1	2	3

Section B:

46. Muscle soreness after moderate exercise	0	1	2	3
47. Vulnerability to insect bites (especially fleas and mosquitoes)	0	1	2	3
48. Loss of muscle tone or "heaviness" in arms or legs	0	1	2	3
49. Enlarged heart and/or heart failure	0	1	2	3
50. Worrier, feel insecure and/or highly emotional	0	1	2	3
51. Pulse slow/below 65 or irregular pulse	YES		NO	

PART III (Continued)

CATEGORY IV

Section A:

52. Sex drive increased 0 1 2 3
53. "Splitting" type headaches 0 1 2 3
54. Memory failing 0 1 2 3
55. Tolerance for sugar reduced 0 1 2 3

Section B:

56. Sex drive reduced or absent 0 1 2 3
57. Abnormal thirst 0 1 2 3
58. Weight gain around hips or waist 0 1 2 3
59. Tendency to ulcers or colitis 0 1 2 3
60. Increased abilitly to eat sugar without symptoms ... 0 1 2 3
61. Menstrual disorders (women) 0 1 2 3
62. Lack of menstruation (young girls) 0 1 2 3

Section C:

63. Difficulty gaining weight, even if large appetite 0 1 2 3
64. Heart palpitations 0 1 2 3
65. Nervous, emotional, and/or can't work under pressure 0 1 2 3
66. Insomnia 0 1 2 3
67. Inward Trembling 0 1 2 3
68. Night Sweats 0 1 2 3
69. Fast pulse at rest 0 1 2 3
70. Intolerant to high temperatures 0 1 2 3
71. Easily flushed 0 1 2 3

Section D:

72. Difficulty losing weight 0 1 2 3
73. Reduced initiative and/or mental sluggishness 0 1 2 3
74. Easily fatigued, sleepy during the day 0 1 2 3
75. Sensitive to cold, poor circulation (cold hands and feet) 0 1 2 3
76. Dry or scaly skin 0 1 2 3
77. "Ringing" in ears/noises in head 0 1 2 3
78. Hearing impaired 0 1 2 3
79. Constipation 0 1 2 3
80. Excessive falling hair and/or coarse hair 0 1 2 3
81. Headaches when awaken/wear off during day 0 1 2 3

Section E:

82. Blood pressure increased 0 1 2 3
83. Headaches 0 1 2 3
84. Hot flashes 0 1 2 3
85. Hair growth on face or body (Question to females) 0 1 2 3
86. Masculine tendencies (Question to females) 0 1 2 3

Section F:

87. Blood pressure low 0 1 2 3
88. Crave salt 0 1 2 3
89. Chronic fatigue/get drowsy 0 1 2 3
90. Afternoon yawning 0 1 2 3
91. Weakness/dizziness 0 1 2 3
92. Weakness after colds/slow recovery 0 1 2 3
93. Circulation poor 0 1 2 3
94. Muscular and nervous exhaustion 0 1 2 3
95. Subject to colds, asthma, bronchitis (respiratory disorders) 0 1 2 3
96. Allergies and/or hives 0 1 2 3
97. Difficulty maintaining manipulative correction 0 1 2 3
98. Arthritic tendencies 0 1 2 3
99. Nails weak, ridged 0 1 2 3
100. Perspire easily 0 1 2 3
101. Slow starter in morning 0 1 2 3
102. Afternoon headaches 0 1 2 3

CATEGORY V

Section A:

103. Frequent skin rashes and/or hives 0 1 2 3
104. Muscle-leg-toe cramping at rest and/or while sleeping 0 1 2 3
105. Fever easily raised/fevers common 0 1 2 3
106. Crave Chocolate 0 1 2 3
107. Feet have bad odor 0 1 2 3
108. Hoarseness frequent 0 1 2 3
109. Difficulty swallowing 0 1 2 3
110. Joint stiffness after rising 0 1 2 3
111. Vomiting frequent 0 1 2 3
112. Tendency to anemia 0 1 2 3
113. "Whites" of eyes (sclera) blue 0 1 2 3
114. "Lump" in throat 0 1 2 3
115. Dry mouth-eyes-nose 0 1 2 3
116. White spots on finger nails 0 1 2 3
117. Cuts heal slowly and/or scar easily 0 1 2 3
118. Reduced or "lost" sense of taste and/or smell 0 1 2 3
119. Susceptible to colds, fevers, and/or infections 0 1 2 3
120. Strong light irritates eyes 0 1 2 3
121. Noises in head or ringing in ears 0 1 2 3
122. Burning sensations in mouth 0 1 2 3
123. Numbness in hands and feet (extremities "go to sleep") 0 1 2 3
124. Intolerant to monosodium glutamate (MSG) ..... YES NO
125. Cannot recall dreams 0 1 2 3
126. Nose bleeds frequent 0 1 2 3
127. Bruise easily, "black and blue" spots 0 1 2 3
128. Muscle cramps, worse with exercise ("charley horses") 0 1 2 3

CATEGORY VI

129. Aware of heavy and/or irregular breathing 0 1 2 3
130. Discomfort in high altitudes 0 1 2 3
131. "Air hunger"/sigh frequently 0 1 2 3
132. Swollen ankles/worse at night 0 1 2 3
133. Shortness of breath with exertion 0 1 2 3
134. Dull pain in chest and/or pain radiating into left arm, worse on exertion 0 1 2 3

CATEGORY VII
Female Only

135. Premenstrual tension 0 1 2 3
136. Painful menses (cramping,etc.) 0 1 2 3
137. Menstruation excessive or prolonged 0 1 2 3
138. Painful/tender breasts 0 1 2 3
139. Menstruate too frequently 0 1 2 3
140. Acne, worse at menses 0 1 2 3
141. Depressed feelings before menstruation 0 1 2 3
142. Vaginal discharge 0 1 2 3
143. Menses scanty or missed 0 1 2 3
144. Hysterectomy/ovaries removed ..... YES NO
145. Menopausal hot flashes 0 1 2 3
146. Depression 0 1 2 3

CATEGORY VIII
Male Only

147. Prostate trouble 0 1 2 3
148. Urination difficult or dribbling 0 1 2 3
149. Night urination frequent 0 1 2 3
150. Pain on inside of legs or heels 0 1 2 3
151. Feeling of incomplete bowel evacuation 0 1 2 3
152. Leg nervousness at night 0 1 2 3
153. Tire easily/avoid activity 0 1 2 3
154. Reduced sex drive 0 1 2 3
155. Depression 0 1 2 3
156. Migrating aches and pains 0 1 2 3

Patient Health History

Today's Date [/ /] **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑ Samoan	❑ Guamanian or Chamorro	❑ Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑ Yes ❑ No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued ...

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____