Dr Maan Dhanjal DC
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FULL NAME: _____ **DATE OF BIRTH:** __ /__ /___ **AGE:** ___ **MALE ☐ FEMALE☐**

ADDRESS: _____ **APT #** _____ **SSN** _____- ____- _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ **HOME PHONE:** (____) _____-_____

ALTERNATE PHONE (CELL): (____) _____-_____ **CELL PHONE COMPANY:** _____

EMAIL ADDRESS: _____ **☐YES ☐NO Text message reminding you of your appointment**

OCCUPATION: _____ **HOW DID YOU HEAR ABOUT US?** _____

MARTIAL STATUS: SINGLE/MARRIED/WIDOWED **EMERGENCY CONTACT:** _____ **PH** (__) ___-_____

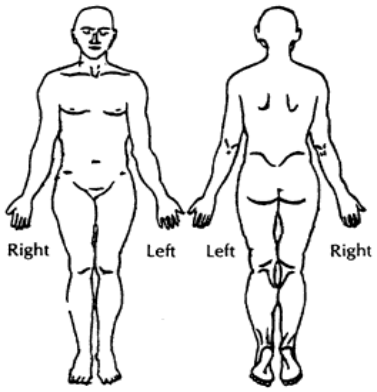
A. Hight:_____ **Weight**_____

What brings you to the office today?

_____

_____

Pain Diagrams: Please mark the location of your pain.



*Pain
^Numbness
tingling
// stiffness
= soreness
+ weakness
" swelling
B-Burning
D-Dull
S-Sharp
>-Shooting
:-Stinging
T-Throbbing

(Please circle all that apply.)

Indicate your level of discomfort

None 0 1 2 3 4 5 6 7 8 9 10 Severe

When are your symptoms worse?

Morning Afternoon Evening Night

Are your symptoms:

Occasional Intermittent Frequent Constant

Are your symptoms:

Improving Worsening Unchanged Other

How and when did your symptoms begin?

_____

What makes your condition better?

_____

What makes your condition worse?

_____

B. Medical History (Please circle all that apply.)

1. YES NO Have you been to a chiropractor?
2. YES NO Do you have a family physician?
3. YES NO Are you or could you be pregnant?
4. YES NO Under the regular care of an OB-GYN?

Since your symptoms began, have you noticed a change in:

Bowel Function
Difficulty Sleeping
Pain when coughing/sneezing
Ability to maintain an erection

(Please circle all of your previous and current illness.)

Arthritis	Ulcer
Asthma	Cancer
Sinus Trouble	Rheumatic Fever
Hay Fever	Polio
Allergies	Serious Injury
Tuberculosis	Bone Fracture
Diabetes	Dislocated Joints
Epilepsy	Spinal Disc Disease
Thyroid Trouble	Multiple Sclerosis
High Blood Pressure	Scoliosis
Low Blood Pressure	Heart Trouble
Prostate Trouble	HIV/ARC
AIDS	Kidney Trouble
Mental/Emotional Difficulty	STD
Other_____	

7. Family History: (Please circle all that apply.)

Cancer	Heart Disease
Diabetes	High Blood Pressure
Stroke	Multiple Sclerosis
Arthritis	Asthma
Other _____	

8. Currently taking any medications/vitamins: YES NO

Anti-inflammatory (Aspirin, Motrin, Tylenol etc.)

Pain Medications/Analgesic Muscle-Relaxants

Birth Control Pills Tranquilizers

Other _____

9. Have you had any surgeries: YES NO

If yes, please explain_____

_____

10. Are you allergic to any medication? YES NO

If yes, please explain_____

C. Review of Systems

What are your habits? (Please circle all that apply.)

Smoking

Never Occasional Moderately Excessively

Alcohol

Never Occasional Moderately Excessively

Recreational Drugs

Never Occasional Moderately Excessively

Exercise

Never Occasional Moderately Excessively

Presently or within the past 6 months, suffered from any of the following?

1. **General**

Normal Chills Night Sweats
Fatigue Weight Change Weakness
Fever Other_____

2. **Skin**

Normal Eczema Rash
Hair Change Redness Nail Change
Itching Other_____

3. **Neurologic**

Normal Fainting Headache
Convulsions Dizziness Other_____

4. **Eyes**

Normal
Vision Trouble R L Pain R L
Discharge R L Other_____

5. **Ears:**

Normal
Hearing Trouble R L Pain R L
Discharge R L Ringing R L
Other_____

6. **Nose:**

Normal Absence of Smell
Pain Bleeding Other_____

7. **Mouth/Throat:**

Normal Sores Bleeding
Absence of Taste Other_____

8. **Heart/Lungs:**

Normal Murmur Cough
Blue Extremities Wheezing Swollen Extremities
Chest Pain Palpitations Difficulty Breathing
Other_____

9. **Breast**

Normal Pain Dimpling
Redness Itching Discharge
Lumps Breast Other_____

10. **Stomach/Intestines:**

Normal Vomiting Constipation
Pain Diarrhea Decreased Appetite
Increased Appetite Other_____

11. **Reproductive/Urination:**

Normal Impotence Sterility
Irregular Menstruation Inability to hold urine
Frequent Urination Painful Menstruation
Painful Urination Abnormal Vaginal Bleeding
Frequent Urination Other_____

12. **Glandular:**

Normal Goiter Heat/Cold Intolerance
Tremor Sugar in Urine other_____

13. **Mental:**

Normal Phobias Depression
Anxiety Mood Swings Memory Loss
Other _____

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for product and services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient or Guardian's Signature Date

_____ ___/___/_____

Doctor's Signature Date

_____ ___/___/_____

Doctor's Notes:

_____

_____

_____

_____