

# Greater Life Family Chiropractic

3689 Midway Dr., Suite G

San Diego, CA. 92110

619-222-8885

## PRACTICE MEMBER INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

E-mail address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

SS# \_\_\_\_\_ Birth Date and Age \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Who can we thank for referring you to us? \_\_\_\_\_

### **Family Information**

[ ] Single [ ] Widowed [ ] Divorced [ ] Married - Spouses Name \_\_\_\_\_

Children's information

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Living at home \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Living at home \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Living at home \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Living at home \_\_\_\_\_

### **Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### **Primary Insurance Information**

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

### **Secondary Insurance Information**

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

I hereby authorize and request my insurance company to pay GLFC/Dr. Henry Wong amount due on my claim for service rendered to me and/or my dependent. I hereby authorized the release of all information necessary to secure the payment of the benefits. I authorize the use of this signature on all insurance submissions. I authorize GLFC/Dr. Henry Wong and whomever he may design as his assistants to administer care, as he deems necessary.

I understand that I am responsible for all costs of chiropractic care regardless of the insurance coverage.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# Health Challenges

Patient Name: \_\_\_\_\_

## What are your most current health concerns?

1. \_\_\_\_\_ Date problem first started? \_\_\_\_\_ Pain severity- 1=mild 10=severity \_\_\_\_\_
2. \_\_\_\_\_ Date problem first started? \_\_\_\_\_ Pain severity- 1=mild 10=severity \_\_\_\_\_
3. \_\_\_\_\_ Date problem first started? \_\_\_\_\_ Pain severity- 1=mild 10=severity \_\_\_\_\_

## Which of the following conditions do you currently have?

- |                                                       |                                                   |                                          |                                                |
|-------------------------------------------------------|---------------------------------------------------|------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Pins & Needles in Legs   | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Neck Pain                    | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Loss of Memory  | <input type="checkbox"/> Stomach/Heartburn     |
| <input type="checkbox"/> Upper Back Pain              | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Menstrual complaints  |
| <input type="checkbox"/> Mid Back Pain                | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Tension         | <input type="checkbox"/> Heart complaints      |
| <input type="checkbox"/> Low Back Pain                | <input type="checkbox"/> Cold Feet                | <input type="checkbox"/> Nervousness     | <input type="checkbox"/> Breathing/Asthma      |
| <input type="checkbox"/> Hip Pain                     | <input type="checkbox"/> Cold Hands               | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Dizziness/Fainting    |
| <input type="checkbox"/> Leg Pain                     | <input type="checkbox"/> Ears Ringing/Buzzing     | <input type="checkbox"/> Depression      | <input type="checkbox"/> Shoulder Pain         |
| <input type="checkbox"/> Other (please explain) _____ |                                                   |                                          |                                                |

## Please list all medications you are currently taking:

Name _____	Dosage _____	How long:? _____	Reason for taking _____
Name _____	Dosage _____	How long:? _____	Reason for taking _____
Name _____	Dosage _____	How long:? _____	Reason for taking _____

## Current supplements: Please list all supplements, vitamins, herbs you presently take:

Name _____	Brand _____	Reason for taking _____
Name _____	Brand _____	Reason for taking _____
Name _____	Brand _____	Reason for taking _____

## Please list any surgeries you have had and briefly describe:

Surgery _____	When _____
Surgery _____	When _____

## **Please list any moving vehicle accidents you have experienced since childhood even what seems to be a minor accident starting with the most recent accident first.**

Type of moving vehicle: \_\_\_\_\_ Date: \_\_\_\_\_ where you the passenger or the driver? P / D (circle one)  
How fast were you going? \_\_\_\_\_ mph. Did you experience any injuries? Y / N (circle one) Did you receive medical care? Y / N

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How fast were you going? \_\_\_\_\_ mph. Did you experience any injuries? Y / N (circle one) Did you receive medical care? Y / N

## **Did you play sports growing up? Y / N (circle one) . Do you currently participate in sports? Y / N (circle one) . Please write down which sports have either participated in or are currently participating in. While playing these sports have you experienced any injuries? If so, describe the injury.**

Sport: _____	how long? _____	Describe the injury: _____	Age: _____
Sport: _____	how long? _____	Describe the injury: _____	Age: _____
Sport: _____	how long? _____	Describe the injury: _____	Age: _____

## **What is your current occupation? \_\_\_\_\_ How long have you been in this profession? \_\_\_\_\_**

Please list your primary job responsibilities: \_\_\_\_\_  
How many hours do you work per day? \_\_\_\_\_ How many hours do you sit? \_\_\_\_\_ Stand? \_\_\_\_\_

Have you ever broken a bone? Y / N (circle one). If so, what bone did you break? \_\_\_\_\_ How did you break your bone? \_\_\_\_\_

Have you ever had stitches? Y / N (circle one). If so, where did you have stitches? \_\_\_\_\_ Why did you need stitches? \_\_\_\_\_

At birth, how were you delivered?  Natural  Suction  Forceps  C-section  Other: \_\_\_\_\_

## **Please list any accidents not listed above, whether at home or other:**

Accident: _____	Date of accident: _____	Type of injury: _____	did you receive care? Y / N <small>(circle one)</small>
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Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_