

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

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

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

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

Signature _____ Print Name _____ Date _____