Dr Paul Tripp DC

901 E. Valley Blvd San Gabriel, CA 91776 Tel: 626-766-1900 Email: PaulTrippDC@gmail.com

Is your visit to our clinic today for care resulting from an auto accident or workers compensation injury?
☐yes ☐no来我诊所是有关车祸或者工伤?

Are you currently in litigation due to any health related problems? ☐yes ☐no
你目前有没有因为与健康有关的问题正在进行法律诉讼?

Today's Date ____/____/____今天日期

Date of Accident ____/____/____ 受伤日期

Last Name 姓_____ First名 _____
M.I.中间名字_____ 中文名

Birthdate生日____/____/____ Age年龄_____ ☐Male 男 ☐Female女

Home Address家庭地址 _____

City城市 _____ State州_____ Zip Code邮编_____

Phones电话 Home住家 _____ Cell 手机_____

☐Single 单身 ☐Married 结婚 ☐Divorced 离婚 ☐Widowed 寡居

EMAIL:_____ Children小孩_____

Emergency Contact紧急联系人_____Phone 电话_____

Do you have Health Insurance ☐yes ☐no
你有没有健康保险
List the name of your insurance: _____
列出保险的名称

ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS

I hereby authorize the insurance carrier listed above to make payments directly to the health care provider and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan it is my responsibility to notify the healthcare provider; otherwise I will be responsible for payment.

Patient Signature _____ Date _____

Chiropractic Case History

Name_____ Sex (M) (F) Date_____ Date of Birth_____ Age_____

Have you ever received Chiropractic Care? Yes No Acupuncture Care? Yes No If yes, when?_____

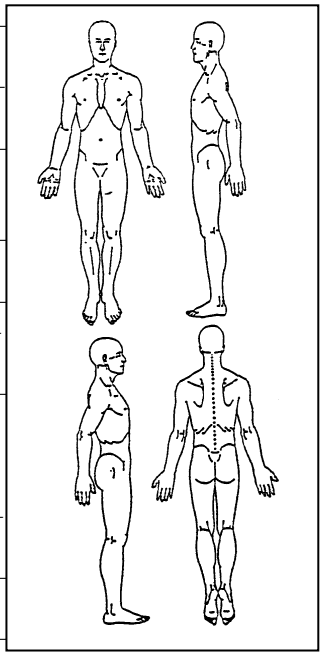
1. Primary reasons for seeking chiropractic/acupuncture care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____



Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: -
dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____
_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

How frequent is complaint present, how long does it last?_____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

6. Social and Occupational History:

(What kind of work have you done?)

A. Job description: _____

B. Work schedule: ( ) Days__( ) Nights__( ) Full time__( ) Part time_____

C. Recreational activities: _____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic/Acupuncture to provide me with chiropractic and/or acupuncture care, in accordance with this state's statutes.

Parent or Guardian Signature X_____ Date _____

Musculo-Skeletal

○ Low back problems
○ Pain between shoulders
○ Neck problems
○ Arm problems
○ Leg problems
○ Swollen joints
○ Painful joints
○ Stiff joints
○ Sore muscles
○ Weak muscles
○ Walking problems
○ Ruptures
○ Broken bones

Genito-Urinary

○ Bladder trouble
○ Excessive urination
○ Scanty urination
○ Painful urination
○ Discolored urine

Female

○ Vaginal discharge
○ Vaginal bleeding
○ Breast pain
○ Lumps on breast
○ Pregnant YES / NO

Gastro-Intestinal

○ Poor appetite
○ Excessive hunger
○ Difficult chewing
○ Difficult swallowing
○ Excessive thirst
○ Nausea
○ Vomiting food
○ Vomiting blood
○ Abdominal pain
○ Diarrhea
○ Constipation
○ Black stool
○ Bloody stool
○ Hemorrhoids
○ Liver trouble
○ Gall bladder problems
○ Weight trouble

Nervous System

○ Numbness
○ Paralysis
○ Dizziness
○ Fainting
○ Headaches
○ Muscle jerking
○ Convulsions
○ Forgetfulness
○ Confusion
○ Depression

Cardio-Vascular-Respiratory

○ Chest pain
○ Pain over heart
○ Difficult breathing
○ Persistent cough
○ Coughing phlegm
○ Coughing blood
○ Rapid heartbeat
○ Blood pressure problems
○ Heart problems
○ Lung problems
○ Varicose veins

Eye, Ear, Nose & Throat

○ Eye strain
○ Eye inflammation
○ Vision problems
○ Ear pain
○ Ear noises
○ Hearing loss
○ Ear discharge
○ Nose pain
○ Nose bleeding
○ Nose discharge
○ Difficult breathing thru nose
○ Sore gums
○ Dental problems
○ Sore mouth
○ Sore throat
○ Hoarseness
○ Difficult speech