Michael J. Snyder, D.C.
1601 Dove St. #170
Newport Beach, CA 92663

CONFIDENTIAL PATIENT INFORMATION

Name_____ Date _____
Home Ph._____ Cell Ph._____
Address _____City _____ Zip _____ S.S.#_____
Age _____ Birth Date_____ Marital Status M S W D How many children? _____
Occupation_____ Employer_____ Office Ph. _____
Work Address_____ Email Address_____
Name of Spouse _____ Occupation _____ Employer_____

Emergency Contact_____Phone (_____)_____
Whom may we thank for referring you to us/how did you hear about us?_____

Your Age_____ Height_____ft._____in. Weight_____lbs

Chiropractors you have seen before:
Name_____City_____State____When_____
Name_____City_____State____When_____

List medical doctors seen within past year:
Name_____City_____State____When_____
Name_____City_____State____When_____
Date of last physical examination_____

X-Rays (last taken and body region)_____
MRI (last taken and body region)_____

List all surgeries:
Type_____When_____
Type_____When_____
Type_____When_____

Past accidents or injuries:
Type_____When_____Hospitalized? Yes_____No_____
Type_____When_____Hospitalized? Yes_____No_____
Type_____When_____Hospitalized? Yes_____No_____

PRIMARY CONDITION – PLEASE DESCRIBE ONE AREA OF COMPLAINT

Please describe your primary complaint: _____

When did it start? _____ Have you had it in the past: ☐ Y ☐ N When: _____

Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

☐ Sharp/Stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _____

Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____

Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _____

What makes it better: _____ Worse: _____

Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing

☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N

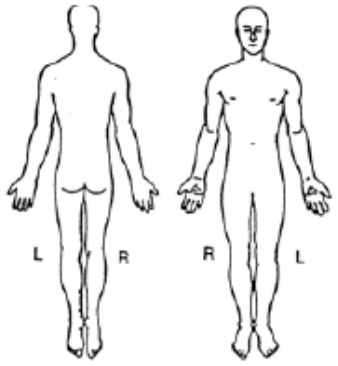
If yes, to either question above, please explain: _____

What other treatment have you had for this condition: _____

☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



SECONDARY CONDITION (If Applicable)

Please describe your secondary complaint: _____

When did it start? _____ Have you had it in the past: ☐ Y ☐ N When: _____

Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

☐ Sharp/Stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _____

Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____

Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _____

What makes it better: _____ Worse: _____

Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing

☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N

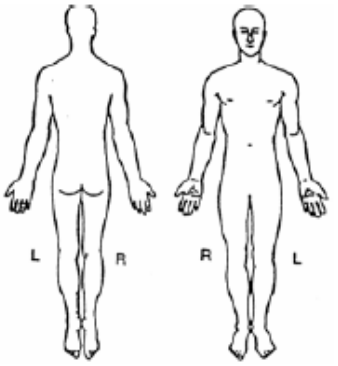
If yes, to either question above, please explain: _____

What other treatment have you had for this condition: _____

☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



ADDITIONAL CONDITION (If applicable)

Please describe any additional complaint: _____

When did it start? _____ Have you had it in the past: ☐ Y ☐ N When: _____

Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

From a scale from 1-10 with 10 being the worst circle the level of pain 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describe the pain:

☐ Sharp/Stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness Other _____

Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____

Have you seen any other doctors for this condition: ☐ Y ☐ N Name: _____

What makes it better: _____ Worse: _____

Do any of the following aggravate your condition? ☐ Walking ☐ Sitting ☐ Coughing

☐ Sneezing ☐ Driving ☐ Breathing ☐ Working ☐ Bowel Movements ☐ Sleeping

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N

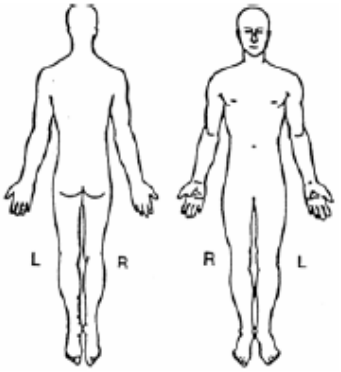
If yes, to either question above, please explain: _____

What other treatment have you had for this condition: _____

☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



Please circle the following activities are affected by your current condition.

Bathing	Cooking	Laying down	Sleep
Bending	Daily pet care	Lifting items	Sneezing
Brushing teeth	Dressing	Reading	Sports
Caring for family	Swallowing	Reaching	Static sitting
Carrying items	Driving	Running	Static standing
Changing of pos.	Eating	Shaving	Washing body/hair
Climbing stairs	Exercising	Showering	Work activities
Computer use	Getting out of bed	Sexual activities	Yard work
Concentration	Household chores		

Past and Present Conditions

Past	Musculoskeletal	Present
[ ]	Neck pain	[ ]
[ ]	Shoulder pain	[ ]
[ ]	Pain in upper arm or elbow	[ ]
[ ]	Hand pain	[ ]
[ ]	Upper back pain	[ ]
[ ]	Low back pain	[ ]
[ ]	Leg pain	[ ]
[ ]	Knee pain	[ ]
[ ]	Pain in ankle or foot	[ ]
[ ]	Jaw pain	[ ]
[ ]	Swelling in joints (list joints) _____	[ ]
[ ]	Stiffness of joints (list joints) _____	[ ]

Past	**Nervous System**	Present
[ ]	Depression	[ ]
[ ]	Insomnia	[ ]
[ ]	Bedwetting	[ ]
[ ]	Fainting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness	[ ]
[ ]	Headache	[ ]
[ ]	Muscular incoordination	[ ]
[ ]	Hearing loss	[ ]
[ ]	Tinnitus (ear noises)	[ ]
[ ]	Ear pain	[ ]
[ ]	Impaired vision	[ ]
[ ]	Eye pain	[ ]
[ ]	Paralysis	[ ]

Past	**Cardiovascular**	Present
[ ]	Rapid heart beat	[ ]
[ ]	Chest pains	[ ]

Past	**Endocrine**	Present
[ ]	Loss of appetite	[ ]
[ ]	Abnormal weight gain	[ ]
[ ]	Abnormal weight loss	[ ]

Past	**Respiratory**	Present
[ ]	Shortness of breath	[ ]
[ ]	Chronic pain	[ ]
[ ]	Chronic cough	[ ]
[ ]	Sinusitis	[ ]

Past	**Gynecologic**	Present
[ ]	Cramps	[ ]
[ ]	Irregular menstrual flow	[ ]
[ ]	Spotting	[ ]
[ ]	Menopausal symptoms	[ ]

Past	**Genito-Urinary**	Present
[ ]	Painful urination	[ ]
[ ]	Loss of bladder control	[ ]
[ ]	Frequent urination	[ ]
[ ]	Urethral discharge	[ ]

Past	**GI Tract**	Present
[ ]	Abdominal pain	[ ]
[ ]	Difficult swallowing	[ ]
[ ]	Heartburn/indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]

Past	**Skin**	Present
[ ]	Rash	[ ]
[ ]	Dermatitis or eczema	[ ]
[ ]	Persistent itching	[ ]

Please check any of the following that apply to you.

[ ] Tobacco
[ ] Alcohol
[ ] Tranquilizers/Sedatives
[ ] Laxatives
[ ] Coffee, cups/day _____
[ ] Regular soda, cans/day _____
[ ] Diet soda, cans/day _____
[ ] Water _____

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

Past	Condition	Present	Past	Condition	Present
[ ]	Hemorrhoids	[ ]	[ ]	Emphysema	[ ]
[ ]	Rheumatic heart disease	[ ]	[ ]	Arthritis	[ ]
[ ]	High blood pressure	[ ]	[ ]	Drug or alcohol dependency	[ ]
[ ]	Angina	[ ]	[ ]	Diabetes	[ ]
[ ]	Heart attack	[ ]	[ ]	Ulcer	[ ]
[ ]	Stroke	[ ]	[ ]	Kidney stones	[ ]
[ ]	Asthma	[ ]	[ ]	Bladder infection	[ ]
[ ]	Gallbladder	[ ]	[ ]	Allergies	[ ]
[ ]	Cancer	[ ]	[ ]	Other_____	[ ]
[ ]	HIV positive/AIDS	[ ]	[ ]	Other_____	[ ]

Family History: Insert age and check any box that applies

	Age (if living)	Heart Dx	High Cholest	High Bl Pressure	Diabetes	Cancer	Anemia	Neck Pain	Low Bck Pain	Carpal Tunnel	Head aches	Obesity
Self												
Mom												
Dad												
Brother												
Sister												
Other ___												

How many hours of sleep do you get per night _____Type of mattress_____
How old is your mattress _____ How many pillows do you sleep with_____
Do you sleep on your: _____Side _____Stomach _____Back
Do you: _____ watch TV in Bed _____Read in bed _____ use a laptop in bed
How many hours a day do you spend on the computer _____Does sitting at the computer bother your condition_____

Do you wear: _____ Arch Supports _____Heal Lifts _____Inserts _____Orthotics _____Braces _____Supports
If so please explain _____
Do you: _____Run _____Bike _____Swim _____ Work Out _____Yoga _____Play other sports
How much and how often do you exercise_____
_____
_____
Is your current condition interfering with your exercise program and if so how _____
_____
_____
If you don't or can't exercise at the moment, what are your future exercise goals_____
_____
_____

List medications and/or vitamins & minerals you are taking:
Type_____For_____How long_____
Type_____For_____How long_____
Type_____For_____How long_____
Type_____For_____How long_____
Type_____For_____How long_____
Type_____For_____How long_____
Type_____For_____How long_____
Type_____For_____How long_____

"I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that payment for services rendered is due at the time of service unless other arrangements are made."

Patient Signature_____ Date_____
Guardian or Spouse's Signature Authorizing Care_____ Date_____
Information Taken By_____ Date_____