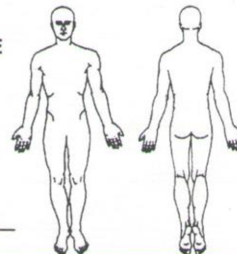
Yorba Linda Family Chiropractic
18613 Yorba Linda Blvd.
Yorba Linda, CA 92886
Tel (714) 777-2500 ▪ Fax (714) 777-1829

William G. Janeshak, D.C.

Patient Name________________________________SSN____________________Birthdate___________Age_____Sex M/F
Address____City_________________________________Height_____
State ________Zip___________ Phone# (____)_______________Patient Primary Language____________ Weight_____
E-Mail Address ______________________________________ **Cell Phone** ________________________________
Occupation________________ Employer__________________________________ Work Phone___________________
Address____ City________________________ State________ Zip___________
Insurance: Yes/No If yes, name of company_____________________ Subscriber's Name______________________
Subscriber ID# _________________Group#______________ Marital Status _______Spouse Name ________________
Spouse Employer ___________________________ City__________________ State____________ Zip________________
Primary Care Physician ____Phone ____________________
Referred by:____
What is the primary reason for your visit today? ____
____

MARK AN X ON THE PITURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:



Y / N Headache, Y / N Neck pain, Y / N Mid-Back Pain, Y / N Low-Back Pain
Other_________________________

Is this: Y/N Work Related Y/N Auto Related N/A
Date Problem Began:___________ How Problem Began___________________________

Current Complaint

0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

How often are your symptoms present? (Please Circle)
(Intermittent) 0-25% 26-5-% 51-75% 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

0	1	2	3	4	5	6	7	8	9	10
(No interference)										(Unable to carry on activities)

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? Y / N (circle)
Date(s) taken _________________________What areas were taken?________________________________

Please circle all of the following that apply to you:

Recent fever
High blood pressure
Corticosteroid use (cortisone, prednisone, etc.)
Taking birth control pills
Pain unrelieved by position or rest
Epilepsy/Seizures
Dizziness/fainting
Pain at night
Osteoporosis

Diabetes
Urinary Problems
Prostrate problems
Stroke (date)_______________
Abnormal weight Gain Loss
Marked morning pain/stiffness
Numbness in groin/buttock
Visual disturbances
Menstrual problems
Currently pregnant, # weeks_____

Cancer/Tumor (explain)____________________
____
Surgeries__________________________
____
Medications________________________
____
Previous illness or trauma_______________
____
Other health problems__________________
____

PLEASE CIRCLE EACH ANSWER

1. Please describe your complaint   Sharp/Dull/Deep/Ache Shooting/Throbbing/Burning/Numbness & Tingling
2. How Frequent is your discomfort   Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)
3. How intense is your pain   (No Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)
4. Are your symptoms: Decreasing   Not Changing   Getting Worse
5. Symptoms are worse in the   Morning   Afternoon   Night   Same all Day
6. Does your pain radiate or travel to other areas in your body?   Yes   No
7. Have you been treated for this condition before?   Yes   No
   If yes, by whom: Chiropractor / MD / PT / Massage Therapist / Other________________
8. What makes your problem better? Nothing/Lying Down/Walking/Standing/Sitting/Inactivity/Movement/Exercise
9. What makes your problem worse? Nothing/Lying Down/Walking/Standing/Sitting/Inactivity/Movement/Exercise
10. How would you rate your general stress level?   Little or No Stress/Minimal/Moderate/Greatly Stressed
11. General Physical Activity: No regular exercise/Light/Moderate/Strenuous Exercise
12. Is your condition affecting your ability to be active? No effect/Able to perform light duty, work & household tasks
    Need limited assistance to perform tasks/Need assistance often/Have a significant inability to function without assistance
    Am totally disabled (impaired), cannot care for myself
13. Physical activity at work: Sitting 50% or more of the day/Light manual labor/Moderate manual labor/Heavy Manual Labor/
    Repetitive motion
14. Has your condition changed your work status: Yes   No
15. What is your current work status?
    Full time, no restrictions/Full time with restrictions
    Part time, no restrictions/ Part time with restrictions
    Off work due to restrictions/Unemployed

Check all that apply

PAST HEALTH HISTORY

Symptoms	Past	Present	Symptoms	Past	Present	Symptoms	Past	Present	
Neck Pain			Headache			Emphysema			
Jaw Pain			Dizziness			Allergies/Sinus			
Shoulder Pain			Nervousness			Ulcers			
Wrist/Hand Pain			Depression			Irritable Bowel			
Upper Back Pain			Memory Loss			Kidney/Bladder			
Lower Back Pain			Sleeping Problems			Kidney Stones			
Hip/Leg Problems			Chronic Fatigue			Hepatitis			
Knee Pain			High Blood Press.			Diabetes			
Foot/Ankle Pain			Heart Problems			Aortic Aneurysm			
Stiff/Swollen Joints			Chest Pain/Angina			Excessive Weight			(Gain or Loss)
Arthritis			Asthma			Cancer			

PRESENT HEALTH STATUS (Please circle)

Tobacco Use:	Never	Infrequent: 1/2 pack per week	Moderate: 1 pk/wk	Heavy 2+ pks/wk
Alcohol Use:	Never	Infrequent 1-2 per week	Moderate 3-5 per wk	Heavy 6+ per wk
Caffeine Use:	Never	Infrequent 1-2 per week	Moderate 3-5 per wk	Heavy 6+ per wk

FAMILY HEALTH STATUS

Please circle the appropriate letter M for Mother's side or F for Father's

Heart Disease	M	F		Back Problems	M	F
High Blood Presure	M	F		Migraines	M	F
Lung Problems	M	F		Epilepsy/Seizures	M	F
Arthritis	M	F		Allergies/Asthma	M	F
Diabetes	M	F		Cancer	M	F

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or it I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature______________________________ **Date**____________________

ASSIGNMENT AND INSTRUCTION FOR THE DIRECT PAYMENT TO:

YORBA LINDA FAMILY CHIROPRACTIC

For Private and Group Health Insurance

Patient Name ____

ID Number ____

Group Number ____

Claim # if applicable ____

I hereby instruct and direct ____ insurance company to pay by check or direct deposit directly to:

Yorba Linda Family Chiropractic

18613 Yorba Linda Blvd

Yorba Linda Ca 92886

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O **Yorba Linda Family Chiropractic**

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For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNEMT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of the said services over and above the insurance payment. I also authorize **Yorba Linda Family Chiropractic** to endorse and apply to my account checks made payable to me for services rendered at **Yorba Linda Family Chiropractic**.

A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to any insurance company, health care professional, adjuster, or attorney involved in this case.

Dated ______________________________, Yorba Linda California

Signature ______________________________________ Witness____________________________