When filling out this form, use the mouse to position the cursor. You can tab to move to the next position on the form or use the 'shift + tab' to move backwards to the previous position. The space bar will fill in the check box.

Saito Chiropractic Office

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

DESCRIBE YOUR CURRENT PROBLEM:

☐ Headache ☐ Neck Pain ☐ Mid-Back pain
☐ Low Back Pain ☐ Other ____________________

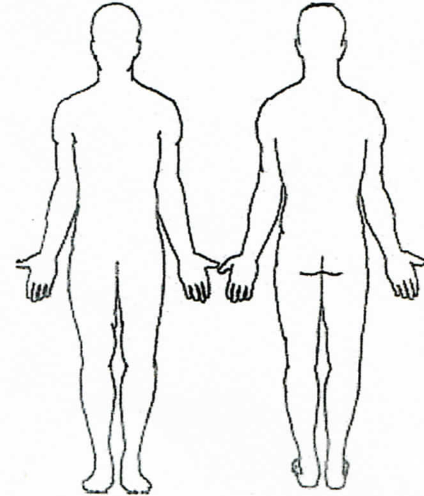
Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began ____________________

How Problem Began

____

____



Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Intense Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 -100%
Can you perform your daily activities? ☐ Yes ☐ No
Describe any current activity limitations ____

Family Health History for Relationship: Mother (M), Father (F), Brother (B), Sister (Si), Son (So), Daughter (D)

Condition/Illness	Relationship	Type		Condition/Illness	Relationship
Cancer				Dementia	
Diabetes				High Cholesterol	
Kidney Disease				Hypertension (high blood pressure)	
Lung Disease				Osteoporosis	
Psychological				☐ Stroke ☐ Heart Disease	

How did you hear about our office? ____

Health Plan (Primary) ____________________ **(Secondary)** ____________________ **(Tertiary)** ____________________

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or 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 I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition need to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature ______________________________ **Date** ____________________