

DR. Jack Hagop T. Hakimian, D.C.

WELCOME TO OUR CLINIC

◆ PLEASE COMPLETE THIS PERSONAL INFORMATION FORM FOR ADMISSION:
Why do you wish to see a doctor of chiropractic today? _____

Is this visit for: ☐ Injury ☐ Auto Accident ☐ On the job Injury
☐ Other _____

◆ **FEMALES ONLY:** ARE YOU OR COULD YOU BE PREGNANT ? ☐ YES ☐ NO

◆ Your(First,Middle,Last)Name please: _____

Home Address: _____

City: _____ St: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____

Age: _____ Date Of Birth: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

No.Children _____ SS# _____ - _____ - _____ Driver Lic# _____

Occupation _____ Employer _____ #Years _____

Work Address _____ City: _____ St: _____ Zip: _____

◆ **EMERGENCY CONTACT** (Relative or Friend) :

Name: _____ Phone () _____

Address _____ City _____ St: _____ Zip: _____

◆ **Health Insurance Information**, please provide the following:

Name: _____ Phone () _____

Policy or I.D. Number: _____ Adjustor: _____

Address _____ City _____ St: _____ Zip: _____

◆ **Other Insurance Information**

Name: _____ Phone () _____

Policy or I.D. Number: _____ Adjustor: _____

Address _____ City _____ St: _____ Zip: _____

Please note: This office will gladly prepare insurance forms and reports; however, the basic responsibility for payment is yours.

◆ Signature: _____ Date: _____

◆ Please draw on the pain diagram, WHERE you FEEL PAIN or DISCOMFORT.

◆ Please SELECT one or more of the FOLLOWING LETTERS A-O to DESCRIBE your pain or discomfort.

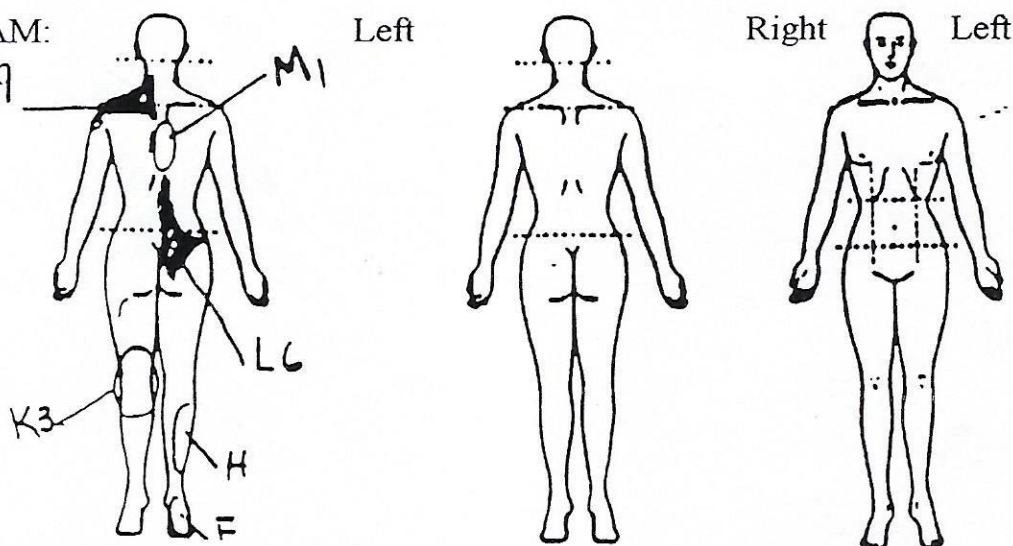
- | | | | | |
|--------------|--------------|---------------|----------------------|---------------|
| [A] Sharp | [D] Shooting | [G] Sensitive | [J] Achy/Sore Muscle | [M] Stiffness |
| [B] Stabbing | [E] Burning | [H] Numb | [K] Throbbing | [N] Headache |
| [C] Crushing | [F] Tingling | [I] Boring | [L] "Just hurts" | |
- [O] Other, Also you can describe your pain in this section: _____

◆ Please rate each area of pain on the pain diagram using the scale 0-10. e.g.; I-2, L-6, A-9

0	1	2	3	4	5	6	7	8	9	10
NO PAIN			Little / Light			Moderate			TOO MUCH PAIN	

PAIN DIAGRAM:

Sample A9



◆ How long have you had this condition ? _____

◆ Have you had this or similar conditions in the past ? ☐ No ☐ Yes

◆ Is this condition getting progressively worse ? ☐ No ☐ Yes ☐ Same

◆ What makes this condition better ? _____

◆ What makes this condition worse ? _____

◆ WHEN do you feel the pain ?

- | | | | |
|---|--------------------------------------|-----------------------------------|---------------------------------------|
| ☐ As soon as I wake up | ☐ Afternoon | ☐ At Night | ☐ All the time |
| ☐ Later in the morning | ☐ Evening | ☐ At Work | ☐ Today only |
| ☐ Comes & Goes | ☐ Other _____ | | |

◆◆◆ **PAST HEALTH HISTORY:**

◆ Please LIST all previous **Surgeries, Hospitalizations, Allergies, Diagnoses** or any health problems in the past:

◆ **OTHER TREATMENTS**

Have you **VISITED another DOCTOR** for this condition before?

☐ No ☐ YES, I have visited a

☐ Medical Doctor ☐ Doctor of Chiropractic ☐ Doctor of Osteopathic

☐ Medical Specialist ☐ Dentist ☐ OTHERS _____

Doctor's Name (who treated you for this condition) _____

Diagnosis _____ X-ray taken ? ☐ Yes ☐ No _____

Other Tests: _____

Urinalysis ? ☐ Yes ☐ No

Blood Tests ? ☐ Yes ☐ No

What kind of treatment did you receive ? _____

Results _____ Time under care _____

◆ **MEDICATION**

Are you taking any ☐ Non-prescription/over the counter medication ☐ vitamins or minerals

What kind _____

Are you taking any **prescribed medications**?

☐ No

☐ Yes

What kind _____

◆ **WORK**

Were you unable to work? ☐ No ☐ YES, how long _____

Have you returned to your same job ☐ YES ☐ No, why not _____

◆ **FAMILY HEALTH HISTORY**

How would you describe the health of your family members: (including age)

Father () _____

☐ Healthy His parents _____

Mother () _____

☐ Healthy Her parents _____

Sisters/Brothers _____

☐ Healthy

Your children _____

☐ Healthy

◆ **HABITS**

How would you describe your general daily habits:

☐ Smoking

☐ heavy

☐ light

☐ none

☐ Coffee

☐ heavy

☐ light

☐ none

☐ Alcohol

☐ heavy

☐ light

☐ none

☐ Exercise

☐ heavy

☐ light

☐ none

◆◆◆ HEALTH QUESTIONNAIRE

Do you or have you ever had:

1. Any type of eye or vision problems? ☐ Yes ☐ No
(blurred, double, partial, or total loss of sight)
☐ Wear Glasses ☐ Near-Sighted ☐ Far-Sighted ☐ Bi-Focals ☐ Contact Lenses
2. Any ear or hearing problems (ringing, buzzing, or any noises in the ears, itching, or pain)? ☐ Yes ☐ No
3. Dizziness or fainting? ☐ Yes ☐ No
4. Temporary lack of understanding? ☐ Yes ☐ No
5. Slurred speech or other speech problems? ☐ Yes ☐ No
6. Difficult swallowing? ☐ Yes ☐ No
7. Loss of consciousness or momentary blackouts? ☐ Yes ☐ No
8. Sudden collapse without loss of consciousness? ☐ Yes ☐ No
9. Numbness or loss of sensation in the face, fingers, hands, arms, legs or other parts of your body? ☐ Yes ☐ No
10. Any abnormal sensations in any part of your body? ☐ Yes ☐ No
11. Weakness, clumsiness or loss of strength in your face, fingers, hands, arms or legs? ☐ Yes ☐ No
12. Have you had a stroke or heart attack? ☐ Yes ☐ No
13. Current or past problems with high blood pressure? ☐ Yes ☐ No
14. Have you ever had any of the following diseases? ☐ Yes ☐ No
☐ Measles (rubeola) ☐ Mumps ☐ Chicken pox
☐ Scarlet fever ☐ Polio ☐ Rubella
15. Have you ever been injured in a motor vehicle accident? ☐ Yes ☐ No
If so when _____
16. Have you ever received care or missed work because of a work related injury? When _____ ☐ Yes ☐ No
17. Do you ever experience shortness of breath? ☐ Yes ☐ No
18. Do you currently or have you ever smoked? ☐ Yes ☐ No
19. Have you experienced any recent weight gain or loss? ☐ Yes ☐ No
20. Any recent difficult sleeping? ☐ Yes ☐ No
21. Have you ever seen a chiropractor before? ☐ Yes ☐ No
22. Any history of benign or malignant tumors? ☐ Yes ☐ No
i.e. cysts, growths, or cancers

◆ Signature: _____

Date: _____

◆◆◆ GENERAL ACCIDENT INFORMATION

What was the date and time of your accident

Date: _____

Time: _____ am/pm

Did your accident occur while at work?

☐ Yes

☐ No

If so, was the injury reported to your supervisor?

☐ Yes

☐ No

Supervisor Name _____

Were you involved in an automobile accident ?

☐ Yes

☐ No

◆ **Location** of accident: _____

◆ In your own words please **describe the accident**: _____

◆ Please describe **how you felt**:

During the accident _____

Immediately after the accident _____

Later that day _____

The next day _____

◆ SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache

☐ Pins & needles/arms

☐ Sleeping problems

☐ Neck pain

☐ Pins & needles/legs

☐ Nervousness

☐ Neck Stiff

☐ Numbness in fingers

☐ Irritability

☐ Back pain

☐ Numbness in toes

☐ Tension

☐ Chest pain

☐ Dizziness

☐ Head seems too heavy

☐ Shortness of breath

☐ Fatigue

☐ Depression

☐ Light bothers eyes

☐ Loss of memory

☐ Ears ring

☐ Face flushed

☐ Buzzing in ears

☐ Loss of balance

☐ Fainting

☐ Loss of smell

☐ Loss of taste

☐ Cold sweats

☐ Diarrhea

☐ Stomach upset

☐ Hands cold

☐ Fever

☐ Constipation

☐ "shock-like feeling"

☐ Feet cold

◆ Signature: _____

Date: _____

◆◆◆ Please check any of the following activities which you have **difficulty performing** or you **perform with pain** since your condition has started:

These activities are not in any particular order.

◆ PERSONAL GROOMING:

- | | | |
|---|---|--|
| ☐ Combing hair | ☐ Shaving | ☐ In & Out of bathtub |
| ☐ Taking a shower | ☐ Brushing Teeth | ☐ Washing your self |
| ☐ Getting in & out of a restroom | | |

Other _____

◆ HOUSEWORK

- | | | | |
|--|---|---|----------------------------------|
| ☐ Cooking | ☐ Washing dishes | ☐ Cleaning | ☐ Mopping |
| ☐ Making Bed | ☐ Vacuuming | ☐ Ironing | ☐ Sewing |
| ☐ Carrying groceries | ☐ Caring for Children | | |
| ☐ Caring for spouse/significant other | ☐ Caring for pets | | |
| ☐ Doing laundry | ☐ Washing car | ☐ Walking the Stairs | |
| ☐ Emptying garbage | ☐ Moving garbage can outside | | |
| ☐ Opening a door | ☐ Twisting a jar | ☐ Using a can opener | |
| ☐ Getting to a water sink | ☐ Grocery shopping | | |

☐ Other _____

◆ YARDWORK

- | | | |
|--|--|--|
| ☐ Mowing lawn | ☐ Gardening | ☐ Raking leaves |
| ☐ Watering Lawn | ☐ Moving Plants | ☐ Trimming Bushes |

☐ Other _____

◆ TRANSPORTATION

- | | |
|---|---|
| ☐ Driving | ☐ Riding as a passenger |
| ☐ Getting in/out of car or bus | ☐ Getting to bus station |
| ☐ Riding your motorcycle | ☐ Riding your bicycle |

☐ Other _____

◆ GENERAL & SOCIAL ACTIVITIES

- | | | | |
|---|--------------------------------------|---|--|
| ☐ Walking | ☐ Standing | ☐ Sitting | ☐ Sleeping |
| ☐ Running | ☐ Lifting | ☐ Lifting children | ☐ Bending |
| ☐ Reading | ☐ Watching TV | ☐ Lying in Bed | ☐ Kneeling |
| ☐ Writing | ☐ Working | ☐ Attending Meetings | |
| ☐ Exercising | ☐ Using phone | ☐ Sitting on a couch or recliner | |
| ☐ Surfing | ☐ Swimming | ☐ Fishing | ☐ Boating |
| ☐ Sexual intercourse | | ☐ Dancing | ☐ Dining out |
| ☐ Climbing upstairs | | ☐ Walking downstairs | |
| ☐ Thinking Straight | | ☐ Remembering | ☐ Understanding |
| ☐ Doing home work | | ☐ Studying | ☐ Hiking |

Other _____

◆ PLEASE LIST any other activity that you can not perform or you perform with pain and discomfort since your condition has started:

◆ Signature: _____

Date: _____

◆◆◆ AUTO ACCIDENT QUESTIONNAIRE (SUPPLEMENT TO GENERAL ACCIDENT QUESTIONS)

Name: _____

1. Were you ? ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat
2. Number of people in your vehicle _____
Were you wearing seat belts ? ☐ Yes ☐ No
3. What direction were you headed? ☐ North ☐ East ☐ South ☐ West
On what street? _____
4. What direction was the OTHER VEHICLE headed?
☐ North ☐ East ☐ South ☐ West
On what street? _____
5. Were you struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side
6. Approximate speed of YOUR CAR _____ mph Other car _____ mph
7. Were you unconscious? ☐ No ☐ Yes How long? _____
8. Did you receive ☐ Fracture ☐ Cuts ☐ Abrasions ☐ Bruises
9. Did any part of your body hit any part of the car ? ☐ No ☐ Yes _____
10. Were you taken to the hospital ☐ No ☐ Yes
Did you go to Hospital ☐ No ☐ Yes
Name of Hospital & the Doctor: _____
Treatment: _____
Confined to Hospital for _____ Days _____ Hours
11. After the hospital, did you visit any doctors or physical therapists for treatment? ☐ No
☐ Yes, please explain _____
12. Have you ever had any other accidents or injuries
☐ Never ☐ Yes, When ? _____
13. Were the areas you are complaining about today injured before?
☐ No ☐ Yes. If so, what were the complaints _____
14. Before the injury, were you capable of working on an equal basis with others your own age? ☐ Yes ☐ No
15. Are your work activities restricted as a result of this accident?
☐ No ☐ Yes, please describe _____
- a. Lost time from work as a result of this accident _____
- b. Last day worked _____
- c. Type of employment _____ Salary _____
- d. Are you being compensated for time lost from work? ☐ No ☐ Yes
if yes, please state type of compensation _____
16. Are any activities restricted as a result of this injury? ☐ No ☐ Yes
if so, describe or ☐ Mark on a Separate Form _____

◆ Signature: _____

Date: _____