Allow up to 2 Hours for Appointment

Consult

Appt Date: _____

Appt Time: _____

"Since 1982"
CRUZ Life CENTER

Natural Health Care Solutions for Your Life

- LASER THERAPY
- CHIROPRACTIC
- HEALTH COACHING

Please Print: Date: _____

Name: _____ Date of Birth: _____

Telephone: Home: _____ Work: _____ Cell: _____

Address: _____

E-Mail: _____

Spouse Name: _____, Number of Children: ___ Social Security Number:_____

Occupation: _____ Where Employed: _____

Where did you hear about us: Newspaper Sign Yellow pages Internet Radio

Who can we thank for referring you to our office: _____

Main Problem

What symptoms caused you to come to the office? _____

_____

What caused this? _____

When did this start? _____ How long do symptoms last? _____

How bad is this? (Circle the one that applies) **Mild, Moderate, Severe, Intolerable**

Please circle what intensity level is your pain at its worst? **Lowest 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10 Highest**

Has your condition gotten: (Circle the one that applies) **WORSE SAME BETTER**

Circle the word or words that best describe any pain. **Cramping, Aching, Dull, Sharp, Shooting, Bright, Lightening like, Diffuse, Throbbing, Deep, Nagging, Dull, Burning, Stinging, Pressure like**

How often does the symptom occur? (Circle the one that applies) **Occasional, Frequent, Constant**

Does any pain travel to any other area? _____

What makes this better? _____

What makes this worse? _____

What else have you done to treat this? _____

Other Problem (Other than what you described above)

What other symptoms do you have? _____

What caused this? _____

When did this start? _____ How long does this last? _____

How bad is this? (Circle the one that applies**)** **Mild, Moderate, Severe, Intolerable**

Please circle what intensity level is your pain at its worst? **Lowest 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10 Highest**

Has your condition gotten: (Circle the one that applies) **WORSE SAME BETTER**

Circle the word or words that best describe any pain. **Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lightening like, Throbbing, Nagging , Burning, Deep, Stinging, Pressure like**

How often does the symptom occur? (Circle the one that applies) **Occasional, Frequent, Constant**

Does any pain travel to any other area? _____

What makes this better? _____

What makes this worse? _____

What else have you done to treat this? _____

Allergies Please list any allergies below including allergies to medications.

_____

Family History

Please tell us about the health of you grandparents, parents, and siblings. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

	Living Deceased	Heart disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease
Paternal Grandfather	**L D** Cause							
Paternal Grandmother	**L D** Cause							
Maternal Grandfather	**L D** Cause							
Maternal Grandmother	**L D** Cause							
Father	**L D** Cause							
Mother	**L D** Cause							
Sibling M F	**L D** Cause							
Sibling M F	**L D** Cause							
Sibling M F	**L D** Cause							

Social History

What do you do at your work? _____

Do you Drink alcohol **Y N** Do you use tobacco **Y N** Do you use recreational drugs **Y N**

Past History

List any injuries in the past year? _____

Have you been hospitalized in past year? _____

Have you had any surgeries? _____

List any illness in the past year not listed above? _____

Have you seen a chiropractor before? **YES** **NO** **When:** _____

What type of care are you looking for? **Temporary Pain Relief** **Fix The Problem** **Discuss with Dr.**

Females: Is there a chance you may be pregnant **Yes** **No**

Please list all types of medications & vitamins you take & for what reason. You may use the back of this form.

_____ _____

_____ _____

_____ _____

_____ _____

If you are taking narcotics for pain, is there a possibility you could be dependent upon the medication: YES or NO

Payment Information

Upon request we can print billing information needed to submit to your insurance company.

PLEASE NOTE: Our office policy is that you will be expected to pay for today's visit.
I will be paying with: **(Circle) Care Credit Cash Check Credit Card Debit Card**

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signed_____ Date_____

Do you have a pacemaker or any metal pins or plates in your body?

☐ Yes Where?_____
☐ No