The California
CRANIAL INSTITUTE

Confidential Patient History

Legal Name: _____ Preferred Name: _____
Address: _____City: _____ State: ____ Zip: _____
Mobile: _____ Phone: _____ Other: _____
Email: _____ Work Email: _____
By providing my email address. I authorize my doctor to contact me via the email address(es) provided.
Date of Birth: _____/_____/_____ Age _____ Sex: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: _____
Names & Ages of Children: _____
_____
Employment Status (check one)
☐ Employed ☐ Self Employed ☐ Student ☐ Retired ☐ Other: _____
Occupation: _____ Employer: _____
Emergency Contact Information | Name: _____ Relationship: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____

Referred by: ☐ Physician ☐ Advertisement ☐ Dentist ☐ Family/Friend ☐Other: _____
Name of Referral: _____

Health Care Provider
Provider/Doctor's Name: _____ Phone Number: _____
Are you currently under the care of a Healthcare Provider or any other doctor?
If yes, for what conditions _____
Has a doctor diagnosed you with hypertension recently? ☐ Yes ☐ No
If yes, describe _____
Has any doctor diagnosed you with Diabetes recently? ☐ Yes ☐ No
If yes, was your blood lab-work test for hemoglobin A1c >9.0% ☐ Yes ☐ No ☐ Not sure
If yes, other comments regarding diabetes _____
Have you had an X-ray or CT scan or MRI of any region of your spine in the past 28 days? ☐ Yes ☐ No
Do you wear any of the following? ☐ Heel Lifts ☐ Innersoles ☐ Arch supports ☐ Orthotics ☐ Other _____
For how long? _____ Were they prescribed by a doctor? ☐ Yes ☐ No

Dental History/Work | Indicate how many of the following you have:
Current Dentist: _____
Phone: _____ Location: _____
Do you wear Mouthguard or Splint? ☐ Yes ☐ No Duration: _____ Prescribed by Dentist? ☐ Yes ☐ No
Current Orthodontist: _____
Phone: _____ Location: _____
Please Check box

☐ Cavities	☐ Extractions	☐ Composites	☐ Bridges	☐ Sensitive teeth
☐ Root Canals	☐ Implants	☐ Veneers	☐ Grinding	☐ Infections/pockets
☐ BioCalex Root Canals	☐ Porcelain crowns	☐ Posts	☐ Clenching	☐ TMJ Pain ☐R ☐ L
	☐ Gold crowns	☐ Dentures	☐ Grinded/worn teeth	
☐ Silver fillings	☐ Steel crowns	☐ Temporaries	☐ Bleeding gums	

Do you need further dental work? _____ If so, what? _____

History of Trauma

History of significant trauma? _____

Minor trauma in person > 50years old? ☐ Yes ☐ No

Do you have osteoporosis (weak bones)? ☐ Yes ☐ No

Are you over 70 years old? ☐ Yes ☐ No

Any history of prolonged use of corticosteroids? ☐ Yes ☐ No

Acute onset urinary tract retention or overflow incontinence (wet underwear)? ☐ Yes ☐ No

Loss of anal sphincter tone or fecal incontinence (bowel accidents)? ☐ Yes ☐ No

Saddle anesthesia (numbness in the groin region)? ☐ Yes ☐ No

Global or progressive muscles weakness in the legs (legs give out)? ☐ Yes ☐ No

Complaints | Please rank your health complaints and rate their severity (on a scale from 1-10, 10 being the worst).

Is this condition due to an accident? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Home ☐ Other Date: _____

_____

_____

_____

_____

_____

_____

_____

_____

What is the Mechanism of accident/injury? _____

When did your symptoms appear? _____ Is it constant or does it come and go? _____

How often do you have this problem? _____ How long does the pain last? _____

Does the pain Radiate? ☐ Yes ☐ No If yes, explain: _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are difficult / painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What time of day is your current pain/problem worse?

☐ Morning ☐ Late in the day ☐ Middle of night ☐ As day Progresses ☐ N/A

My current pain/problem seem to be:

☐ Getting Better ☐ Staying the same ☐ Getting worse ☐ N/A Explain: _____

My Current pain/problem can be described as (check all that apply):

☐Electric	☐Deep	☐Knife-like	☐Achy	☐Heavy	☐Stiffness	☐N/A
☐Burning	☐Stabbing	☐Piercing	☐Griping	☐Tearing	☐Am >1-2hr	
☐Sharp	☐Superficial	☐Shooting	☐Spasm	☐Cramp-like	☐Pm or ☐both	

Other Information | Please tell us any additional information or concerns about your health.

_____

_____

_____

_____

_____

Injuries (list date next to injury)

☐Back injury	☐Fall (severe)	☐Industrial accident	☐Motor vehicle accident
☐Broken bones	☐Fracture	☐Joint injury	☐Soft tissue injury
☐Disability(ies)	☐Head injury	☐Lacerations (severe)	☐Other_____

Medical History | Please describe any conditions which are under the care of a physician.
Diagnosis: _____
Date of onset: _____ Duration of current symptoms: _____
Doctor(s) involved, their specialty: _____
How diagnosed (what tests?): _____
Current treatment (medication, etc.): _____
Treatment received in past, if any, and how it worked: _____

Surgeries/Hospitalizations | What surgeries, operations, traumas, fractures, car accidents, etc. have you had?

☐ Appendectomy ☐ Biopsies ☐ Cosmetic Surgery ☐ Laparoscopy ☐ Implants / Prostheses
☐ Arthroscopy ☐ Body piercings ☐ D&Cs ☐ Plastic or metal inside your body ☐ Tonsils/Adenoid
☐ Breast Implants ☐ C-Sections ☐ Eye Surgery

	Date	Procedure	Description/Outcome
1			
2			
3			
4			
5			

Medications | Please list any medications you are taking, or have taken in the past, and for how long. State the reason for taking it.

☐ Antacids ☐ Birth Control Pills ☐ Hormones (estrogen, progesterone, DHEA, testosterone, thyroid) ☐ Pain Killers ☐ Yeast/Fungal Meds
☐ Antibiotics ☐ Blood Pressure Meds ☐ Muscle Relaxers ☐ Parasite Medication ☐ Recreational Drug
☐ Antidepressants ☐ Cardiac/Heart Meds ☐ Steroids (prednisone, anabolic, cortisone)
☐ Antihistamines ☐ Diuretics
☐ Anti-inflammatory

Please complete the following information as completely as possible. This helps us to address your concerns and needs, and to build a health program personally designed for you.

Stress Level | Rate your stress level currently on a scale from 1-10 (10 being the most stress). Note that stress can come in forms such as overwork, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, not happy with life, depression, etc.
Overall stress: _____ Main reasons for stress: _____
_____
If over a level 5, what steps are you currently taking to reduce your stress?
_____

Energy Level | List on a scale from 1-10 (1 is lowest, 10 is highest) what is your energy level during the following times:
AM _____ Afternoon _____Evening _____ Late PM _____ After meals _____Overall _____

Sleep Quality | How is your sleep? (check all that apply) ☐ Restful ☐ Restless ☐ Hard to get sleep ☐ Wake up often ☐ Nightmares What time do you usually go to sleep? _____ Hours of sleep/night? _____
Type of mattress? _____How old is it? _____ Type of pillows, sheets, and blankets? _____

Exercise | Do you exercise? _____ How often? _____For how long per session? _____
What type of exercise do you do? _____

Allergy
Are you allergic to any medications(s)? ☐Yes ☐No If yes, which medications? _____
Are you allergic to any of the following?

☐Bee Sting ☐Latex ☐Peanuts ☐Wheat
☐Dairy ☐Mold ☐Pollen ☐Other: _____
☐Eggs ☐Nuts ☐Shellfish _____

Describe the reaction: _____

Childhood Illness

☐ADD	☐Bedwetting	☐Diabetes	☐HIV	☐Scoliosis
☐Atopic dermatitis	☐Cerebral palsy	☐Ear infection	☐Measles	☐Seizures
☐Allergies/Hayfever	☐Chick pox	☐Fetal drug exposure	☐Mumps	☐Sickle cell
☐Anemia	☐Crohn;s/colitis	☐Headache	☐Psoriasis	☐Spina bifida
☐Asthma	☐Depression	☐Hepatitis	☐Rash	☐Other

Adult illnesses

☐ADD	☐CVA(stroke)	☐Heart Disease	☐Multiple sclerosis	☐Seizures
☐Alzheimer's	☐Cystic kidney disease	☐Hepatitis	☐Parkinson's disease	☐Shingles
☐arthritis	☐Depression	☐HIV	☐Unspecified pleural effusion	☐STD'S(unspecified)
☐asthma	☐Diabetes	☐high blood pressure	☐Pneumonia	☐Suicide attemp(s)__
☐cancer	☐Eczema	☐Influenza	☐Psoriasis	☐Thyroid Problems
☐cerebral palsy	☐Emphysema	☐pneumonia	☐psychiatric condition	☐Vertigo
☐chicken pox	☐Eye Problems	☐Liver disease	☐Scoliosis	☐Other
☐colitis	☐Fibromyalgia	☐Lung disease		
☐CRPS(RSD)		☐Lupus erythema		

Family History | Check those that apply and indicate the outcome and age of onset.

	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Mother	Father	Brother	Sister	Onset	Outcome
Allergies	☐	☐	☐	☐	☐	☐	☐	☐		
Arthritis (type)	☐	☐	☐	☐	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐		
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Thyroid Imbalance	☐	☐	☐	☐	☐	☐	☐	☐		

Other _____

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at the California Cranial Institute at this time.

_____

Patient Signature Date

_____

Signature of Parent or Legal Guardian Relationship

The California
CRANIAL INSTITUTE

Review of Systems

Review of Systems | Please check the "NOW" box for all conditions that you are NOW experiencing and mark the "PAST" box for any condition or symptoms experienced at any time in your life. (Writing 'N' and 'P' are fine too

Constitutional
☐None
☐Chills
☐Daytime drowsiness
☐Fatigue
☐Fever
☐Loss of appetite
☐Night sweats
☐Weight gain
☐Weight loss

Eye/vision
☐None
☐Change in vision
☐Cataracts
☐Light sensitivity
☐Flashes in vision
☐Spots in vision
☐Blindness
☐Blind spots
☐Cataracts
☐Double vision
☐Eye problems
☐Itching
☐Photophobia
☐Tearing
☐Wears contacts/glasses

Ears, nose & throat
☐None
☐Dizziness
☐Ear discharge
☐Ear pain
☐Fainting
☐Frequent sore throats
☐Headaches
☐Hearing loss
☐History of head injury
☐Loss of sense of smell
☐Nosebleeds
☐Nasal congestion
☐Runny nose
☐Sinus infection

Mouth
☐Bleeding gums
☐Cold sores
☐Dentures
☐Jaw pain
☐Changes in taste
☐Hoarseness

Respiration
☐None
☐Asthma
☐Cough
☐Coughing up blood
☐Shortness of breath
☐Sputum production
☐Wheezing

Cardiovascular
☐None
☐Claudication (legpain and ache)
☐Heart problem
☐Heart murmur
☐High blood pressure
☐Low blood pressure
☐Orthopnea (difficulty breathing lying down)
☐Palpitations
☐Paroxysmal
☐Nocturnal
☐Dyspnea
☐Shortness of breath with exertion
☐Ulcers
☐Varicose veins

Gastrointestinal
☐None
☐Abdominal pain
☐Abdominal stool (color/consistency)
☐Belching
☐Black/tarry stool
☐Bloating
☐Constipation
☐Diarrhea
☐Difficulty swallowing
☐Heartburn
☐Hemorrhoids
☐Indigestion
☐Jaundice
☐Ulcers
☐Rectal bleeding
☐Vomiting/Nausea
☐Loss of bowel control
☐Hemorrhoids

G-U System
☐Difficulty urinating
☐Pain urinating
☐Blood in urine
☐Incontinence
☐Foul odor of urine
☐Increased urination
☐Decreased urination
☐Urinary infection
☐Genital infection

Female
☐None
☐Abnormal vaginal
☐Bleeding
☐Birth control
☐Breast lump/pain
☐Burning urination
☐Frequent urination
☐Hormone therapy
☐Irregular menstruation
☐Vaginal discharge
☐Urine retention/incontinence
☐Cramps

I ☐ am currently pregnant ☐ an NOT currently pregnant | I ☐ currently have menses ☐ currently DO NOT have menses
My Menses ☐ are regular ☐ are NOT Regular | ___ age of first menses | ____age when menopause began
Date of last menstrual period ____/_____/____ Have you had a hysterectomy (indicate date, partial or total):_____
If you have been pregnant in the past, please fill in appropriate information below
Number of complicated pregnancies _____ Number of uncomplicated pregnancies _____ Number of C sections _____
Number of miscarriages _____ Number of vaginal deliveries _____ Number of terminated pregnancies _____

Males
☐None
☐Erectile dysfunction
☐Burning urination
☐Hesitancy/dribbling
☐Frequent urination
☐Urine retention/incontinence
☐Prostate problems

Sexual history
Do you have any concerns about your sexual health? ☐Yes ☐No

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Are you or have you ever been a victim of domestic or sexual abuse? ☐Yes ☐No

Skin
☐None
☐Bruising
☐Change in nail texture
☐Change in skin color
☐Hair loss
☐Hives
☐History of skin disorders
☐Itching
☐Numbness
☐Peeling
☐Rash
☐Skin lesion/ulcers
☐Varicosities

Muscle/Bone
☐Joint pain
☐Stiffness
☐Muscle ache
☐Arthritis
☐Bone pain
☐Fractures
☐Dislocations

Nervous system
☐None
☐Dizziness
☐Facial weakness
☐Headache
☐Limb weakness
☐Loss of consciousness
☐Loss of memory
☐Numbness
☐Seizures/Epilepsy
☐Sleep disturbance
☐Slurred speech
☐Stress
☐Stroke
☐Unsteadiness of gait
☐Loss of balance
☐Tingling sensation

Psychological
☐None
☐Anxiety
☐Behavioral change
☐Bi-polar disorder
☐Confusion
☐Convulsions
☐Depression
☐Insomnia
☐Loss or change of appetite
☐Memory loss
☐Mood change

Hematologic
☐None
☐Anemia
☐Bleeding
☐Blood clotting
☐Blood transfusion
☐Bruising easily
☐Fatigue
☐Lymph node swelling

Respiratory
☐Difficulty breathing
☐Asthma
☐Pneumonia
☐Wheezing
☐Persistent cough
☐Coughing phlegm
☐Coughing blood
☐Tuberculosis

Vascular
☐Chest pain
☐Palpitations
☐Ankle swelling
☐Cold feet/hands
☐Leg cramps
☐Calf pain
☐Varicose veins
☐Low blood pressure
☐High blood pressure

Do you have a past history of cancer? ☐ Yes ☐ No
Have you had any unexplained weight loss? ☐ Yes ☐ No
Your pain does not improve with rest? ☐ Yes ☐ No
Are you over 50 years old? ☐ Yes ☐ No
Failure to respond to course of conservative care (4-6weeks) ☐ Yes ☐ No
Have you had a spinal pain greater than 4 weeks? ☐ Yes ☐ No

Prolonged use of corticosteroids (such as organ transplant Rx)? ☐ Yes ☐ No
Intravenous drug use? ☐ Yes ☐ No
Current or recent urinary tract, respiratory tract or other infection? ☐ Yes ☐ No
Immunosuppression medication and/or conditions? ☐ Yes ☐ No
Are you currently or have you used blood thinners? ☐ Yes ☐ No

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at the California Cranial Institute at this time.

Patient Signature Date

Signature of Parent or Legal Guardian Relationship

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