LIONHEART CHIROPRACTIC
DR CHERYL GRAHAM, DC

710 RIVER STREET, SUITE 7
SANTA CRUZ, CA 95060
831-515-9004

PLEASE TELL US ABOUT YOURSELF

Name (last)____________________ (first)____________________________________ (mi) _____________
Home Address (street)____.
(City) ________________________________ (state)_________________________ (zip)_____________________.
Home Phone (____)__________________ Mobile (___)____
Birthdate____ /___ /_____ Age______ Social Security #______-____-_________
Email Address____(Your email with not be shared with any 3rd parties, and is used for occasional office announcements and promotions.)
Occupation__________________________Employer____
Work Phone (____)_____-_______ Ext._______
Male / Female / Other (please circle)
Single / Married / Partnered / Divorced / Widowed / Separated
Spouse/Partner's Name (last)______________________ (first)____
Employer Work Phone (___)_____________________
Number of Children Names and Ages: ____
Emergency Contact Phone (____) ______________
Whom may we thank for referring you to LionHeart Chiropractic? ____

Current Health
In general, how would you say your general health is? ____ Excellent ___ very good _____good _____fair ____ poor
Current complaints and reason for consulting LionHeart Chiropractic?
____
____
If Injury, what was the nature: Automobile________ Work _______ Other _______________Date of Injury:________
Please describe:
____
____
Current complaints: How do you feel today? 0/10 no pain to 10/10 unbearable pain: ____________________________
How often are your symptoms present? 0-25%____ 26-50%________51-75%__________76-100%(constant)
How much does your pain interfere with your daily activities of living, such as work, social activities, or household chores? 0/10 (no interference) to 10/10 (unable to do any activities of daily living): ____________________________
Have you seen another Doctor or practitioner for this complaint? If yes, who and when? __________________________
____
Have you had any spinal X-rays, MRI, CT scan for any of your areas of complaint?
____

Have you experienced this same pain in the past? _____________ If yes, when and describe situation:
____
Have you ever been under Chiropractic care? If yes, when are where?
____
How has this affected your life (family, occupation, recreation, concern for future health, etc)?
____
____
____

Medical History:
Ever been Hospitalized?
____
Any surgeries? ____
Broken bones?____
Auto accidents?____
Sprains/strains? ____
Struck unconscious?____

Please check all that apply to you:

- o Alcohol/drug dependence
- o Allergies
- o Anemia
- o Arthritis
- o Asthma
- o Diabetes
- o High blood pressure
- o Stroke/heart problems
- o Dizziness/fainting
- o Bruise easily
- o Cold extremities
- o Digestive issues
- o Chest pain/conditions
- o Depression
- o Ears ringing
- o Fatigue
- o Headaches
- o Loss of balance
- o Loss of memory
- o Loss of smell
- o Loss of taste
- o Sleep problems/insomnia
- o Swollen joints
- o Thyroid condition
- o Numbness in groin or buttocks
- o Cancer/tumor
- o Osteoporosis
- o Epilepsy/seizures
- o Prostrate problems
- o Menstrual problems
- o Urinary problems
- o Currently pregnant? ____#of weeks?___
- o Abnormal weight gain or loss?
- o Marked morning pain/stiffness
- o Pain unrelieved by position or rest
- o Pain at night
- o Visual disturbances

Family History:

- o Cancer
- o Diabetes
- o High blood pressure
- o Heart problems/stroke
- o Rheumatoid arthritis
- o Other:_____________

Habits:

Please say none, light, moderate or Heavy (you can put N, L, M, H)

________Alcohol ________Coffee _____Tobacco _______Drugs _______Exercise ________Sleep

________Appetite ______Soft drinks ______Water _____Salty foods ______Sugary foods _____ Artificial sweeteners

Is there anything else you would like us to know?

____

____

____

If using insurance:

Subscribers name: ________________________________ Subscribers ID number ___________________________

Health Plan ___________________________ Group # ____________________

Primary Care Physician name:____

Payment options are: Cash, credit card, some health insurances, and Care Credit.

Please read and sign:

I certify to the best of my knowledge, that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive health care benefit through this practitioner, I understand that I am liable for all charges for services rendered in a timely payment and I agree to notify this practitioner 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 needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature: ____ Print name: ___________________________

Date: _________________________