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:_____

_____

_____

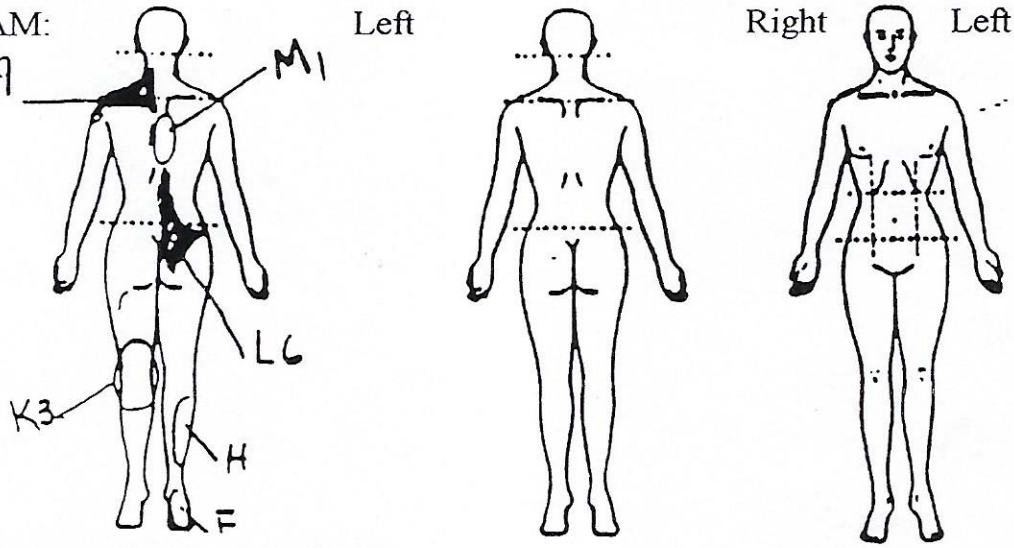
_____

◆ 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:



◆ 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 UESTIONS)

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: _____