Hagop Jack T. Hakimian, D.C.

Patient History Form

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

PERMANENT ADDRESS
Address:_____
City:_____ St:____ Zip:_____
Phone: ( ) _____
Work Phone: ( ) _____
Employer:_____

LOCAL ADDRESS ☐Same
_____
_____
Phone: ( ) _____
Occupation:_____
Address:_____
Emergency Contact Phone: ( ) _____ Name:_____

Age:___ Date Of Birth: _____ SS# ___-___-___ Driver Lic# _____
☐ Male ☐ Female ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced No. Children _____
◆◆ ◆Are you pregnant? ☐Yes ☐No
◆How can we help you, today ?_____
_____
◆ Please draw on the pain diagram, WHERE you feel PAIN or DISCOMFORT.
◆ Please rate each area of pain and select the letter[s] to describe the pain on the pain diagram

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

◆ How long have you had this condition ? _____
◆ Have you had this or similar conditions in the past? ☐ No ☐Yes, _____
◆ What makes this condition better ? _____
◆ What makes this condition worse ? _____
◆ WHEN do you feel the pain ?_____

◆◆◆PAST HEALTH HISTORY:
◆ Have you had any ☐Serious health problems or ☐Life threatening condition
_____
_____

◆Have you had any of the following :

☐High Blood Pressure	☐Epilepsy	☐Cancer/Tumor	☐Broken Bone	☐PaceMaker
☐Heart Attack/Stroke	☐Dizziness	☐Arthritis	☐Scoliosis	☐Blackout
☐Breathing Problem	☐Disc Problem	☐Liver Problem	☐Abusive Relationship	
☐Emotional Problem	☐Eye Problem	☐Fainting	☐Assault	☐Domestic Violence
☐Kidney Problem	☐Ear Problem	☐Diabetes	☐Alcohol Abuse	☐Drug abuse
☐Urinary Problem	☐SuddenCollapse	☐Chronic Pain	☐other _____	

◆☐ Any condition or disease in the family _____
◆☐ Surgeries, ☐Hospitalizations, ☐Allergies, ☐Car Accidents, ☐Injuries, ☐Work Injuries
Please explain each incident with date. *For example, skiing-broken right ankle 1987*
_____
_____
_____
_____

◆ MEDICATION ☐None ☐Prescribed, ☐Over the Counter, ☐Vitamins & Minerals
_____
_____

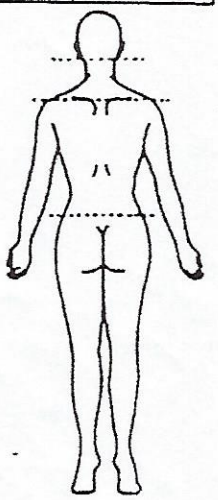
◆ Have you visited other DOCTORs for this condition? ☐No Date of Last Visit: _____
Name _____ Diagnosis_____
Address _____
Doctor's Phone: ( ) _____
TESTS: ☐X-rays, ☐UltraSound, ☐MRI, ☐CT-Scan, ☐Bone Scan, ☐Blood Test, ☐Urine Test
Treatment you received ? _____
_____

◆ Insurance Coverage *(Copy of the Insurance Card)*
_____

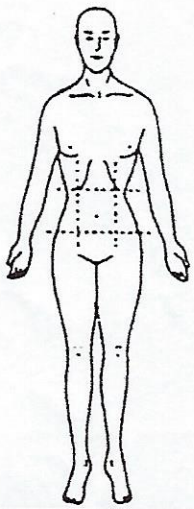
◆Please Note: Our office can process your insurance forms; however, you are responsible for the full payment of all our clinical services and any collection fee, attorney fee, and 12% interest rate for the past due amount.

Signature:_____ Date:_____

Left BACK Right



Pain Description
[A] Sharp
[B] Stabbing
[C] Crushing
[D] Shooting
[E] Burning
[F] Tingling
[G] Sensitive
[H] Numb
[I] Boring
[J] Achy/Sore
[K] Throbbing
[L] "Just Hurts"
[M] Stiffness
[N] Headache
[O] Other



Right Front Left