



CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Gentle Chiropractic Care
Dr. Dianne McClintock
1365 McDonald Road
Fallbrook, CA 92028
(760) 723-5890 Fax (760) 687-0022
www.diannemcclintock.com
drdiannemcclintock@gmail.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

VA authorization / Patient Number

Whom may we thank for referring you?

☐ No ☐ Yes

When?

If so, whom?

Age

Gender

☐ Male ☐ Female

Birth Date (MM/DD/YYYY)

Last four digits of your Social Security Number

Your Last Name

Smoking Status (age 13 and over)

☐ Never A Smoker ☐ Former Smoker
☐ Current Every Day Smoker ☐ Current Some Day Smoker
☐ Heavy Smoker ☐ Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status ☐ Married

☐ Single ☐ Divorced

City

State/Province

ZIP/Postal Code

☐ Widowed ☐ Separated

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

☐ Yes ☐ No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

☐ Home Phone ☐ Cell Phone
☐ Work Phone ☐ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

☐ Self ☐ Spouse ☐ Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

☐ An accident or injury

☐ Work

☐ Auto

☐ Other _____

☐ In-Service Related Injury

☐ A worsening long-term problem

☐ An interest in: ☐ Wellness ☐ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication

☐ Acupuncture

☐ Over-the-counter drugs

☐ Chiropractic

☐ Homeopathic remedies

☐ Massage

☐ Physical therapy

☐ Ice

☐ Surgery

☐ Heat

☐ Other _____

Secondary Complaint

The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

☐ An accident or injury

☐ Work

☐ Auto

☐ Other _____

☐ In-Service Related Injury

☐ A worsening long-term problem

☐ An interest in: ☐ Wellness ☐ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication

☐ Acupuncture

☐ Over-the-counter drugs

☐ Chiropractic

☐ Homeopathic remedies

☐ Massage

☐ Physical therapy

☐ Ice

☐ Surgery

☐ Heat

☐ Other _____

Additional Complaint

The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

☐ An accident or injury

☐ Work

☐ Auto

☐ Other _____

☐ In-Service Related Injury

☐ A worsening long-term problem

☐ An interest in: ☐ Wellness ☐ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication

☐ Acupuncture

☐ Over-the-counter drugs

☐ Chiropractic

☐ Homeopathic remedies

☐ Massage

☐ Physical therapy

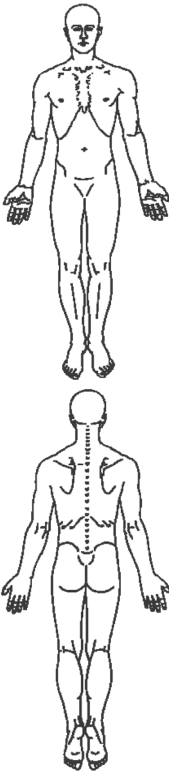
☐ Ice

☐ Surgery

☐ Heat

☐ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



1. What else should Dr. McClintock know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
☐ Osteoporosis	☐ Arthritis	☐ Scoliosis	☐ Neck pain	☐ Back problems	☐ Hip disorders	Initials _____
☐ Knee injuries	☐ Foot/ankle pain	☐ Shoulder problems	☐ Elbow/wrist pain	☐ TMJ issues	☐ Poor posture	

b. Neurological

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
☐ Anxiety	☐ Depression	☐ Headache	☐ Dizziness	☐ Pins and needles	☐ Numbness	Initials _____

c. Cardiovascular

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
☐ High blood pressure	☐ Low blood pressure	☐ High cholesterol	☐ Poor circulation	☐ Angina	☐ Excessive bruising	Initials _____

d. Respiratory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
☐ Asthma	☐ Apnea	☐ Emphysema	☐ Hay fever	☐ Shortness of breath	☐ Pneumonia	Initials _____

e. Digestive

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
☐ Anorexia/bulimia	☐ Ulcer	☐ Food sensitivities	☐ Heartburn	☐ Constipation	☐ Diarrhea	Initials _____

f. Sensory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
☐ Blurred vision	☐ Ringing in ears	☐ Hearing loss	☐ Chronic ear infection	☐ Loss of smell	☐ Loss of taste	Initials _____

g. Skin

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
☐ Skin cancer	☐ Psoriasis	☐ Eczema	☐ Acne	☐ Hair loss	☐ Rash	Initials _____

Patient name _____

VA authorization /
Patient Number _____

Doctor's Initials _____

Gentle Chiropractic Care
Dr. Dianne McClintock

(Continued from previous page)

h. Endocrine

Had Have Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Thyroid issues ☐ ☐ Immune disorders ☐ ☐ Hypoglycemia ☐ ☐ Frequent infection ☐ ☐ Swollen glands ☐ ☐ Low energy Initials _____

i. Genitourinary

Had Have Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Kidney stones ☐ ☐ Infertility ☐ ☐ Bedwetting ☐ ☐ Prostate issues ☐ ☐ Erectile dysfunction ☐ ☐ PMS symptoms Initials _____

j. Constitutional

Had Have Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Fainting ☐ ☐ Low libido ☐ ☐ Poor appetite ☐ ☐ Fatigue ☐ ☐ Sudden weight gain/loss (circle one) ☐ ☐ Weakness Initials _____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL		4. Illnesses	5. Operations	6. Treatments																																																																																																																																																																																																																												
		Check the illnesses you have Had in the past or Have now.	Surgical interventions, which may or may not have included hospitalization.	Check the ones you've received in the Past or are receiving Currently .																																																																																																																																																																																																																												
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Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. McClintock about the health of your immediate family members.

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
			☐	☐			☐	☐
	Mother	_____	☐	☐	_____	_____	☐	☐
	Father	_____	☐	☐	_____	_____	☐	☐
	Sister 1	_____	☐	☐	_____	_____	☐	☐
	Sister 2	_____	☐	☐	_____	_____	☐	☐
	Brother 1	_____	☐	☐	_____	_____	☐	☐
	Brother 2	_____	☐	☐	_____	_____	☐	☐
	_____	_____	☐	☐	_____	_____	☐	☐

10. Are there any other hereditary health issues that you know about?

11. Social History

Tell Dr. McClintock about your health habits and stress levels.

SOCIAL	Alcohol use	☐ Daily	☐ Weekly	How much? _____	Prayer or meditation?	☐ Yes	☐ No
	Coffee use	☐ Daily	☐ Weekly	How much? _____	Job pressure/stress?	☐ Yes	☐ No
	Tobacco use	☐ Daily	☐ Weekly	How much? _____	Financial peace?	☐ Yes	☐ No
	Exercising	☐ Daily	☐ Weekly	How much? _____	Vaccinated?	☐ Yes	☐ No
	Pain relievers	☐ Daily	☐ Weekly	How much? _____	Mercury fillings?	☐ Yes	☐ No
	Soft drinks	☐ Daily	☐ Weekly	How much? _____	Recreational drugs?	☐ Yes	☐ No
	Water intake	☐ Daily	☐ Weekly	How much? _____			
	Hobbies:	_____					

Doctor's Initials

Gentle Chiropractic Care
Dr. Dianne McClintock

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐

13. What is the major stressor in your life? _____ 14. How much sleep do you average per night? _____ Hours

15. What is the type and approximate age of your mattress and pillow? _____ 16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____

I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient name _____

VA authorization /
Patient Number _____

Consultation Notes

Doctor's Initials _____

Gentle Chiropractic Care
Dr. Dianne McClintock

Patient (or Guardian's) signature _____

Date (MM/DD/YYYY) _____