Khalsa Chiropractic
5880 San Vicente Blvd, Suite 101, Los Angeles, CA 90019 · Phone (323) 857-1277 · Fax (323) 857-1574

Confidential Patient Information

Please fill out this form and bring it to your visit. You can type into it on a computer and then print it, or print it and fill it out by hand. If you need help with this form, call us at (323) 857-1277.

Today's date

About you

Full name

Cell phone	Home phone

Street address

City	State	ZIP code

Age	Birth date	How many children?

Marital status

◯ Married ◯ Single ◯ Widowed ◯ Divorced

Occupation

Employer	Work phone

Emergency contact

Emergency contact name	Relationship to you	Emergency contact phone

Insurance and referral

Name of insurance company

Referred by

Your condition

Purpose of this appointment (major complaint)

Date symptoms appeared or accident happened

Have you had the same or a similar condition before?
◯ Yes ◯ No

If yes, when? Please describe.

Is your condition due to an injury or illness from your job?
◯ Yes ◯ No

Is your condition due to a car accident or other accident?
◯ Yes ◯ No

If your condition is due to an accident, please also fill out the Accident Questionnaire.

Have you lost any days from work? If so, how many?

What activities aggravate your condition?

Is this condition:
◯ Constant ◯ Comes and goes ◯ Getting progressively worse ◯ Improving

Is this condition interfering with your:
☐ Work ☐ Sleep ☐ Daily routine ☐ Other:

How long has it been since you really felt good?

What do you believe is wrong with you?

Other doctors seen for this condition

Have you ever been under chiropractic care? ◯ Yes ◯ No	**Chiropractor's name**

Medical history

Name of primary care physician	Physician's phone

Physician's address

Date of last physical exam	Are you pregnant?
	◯ Yes ◯ No ◯ Not applicable

Past surgeries

Serious illnesses

Have you been treated for any health conditions by a physician in the last year?

◯ Yes ◯ No

If yes, please describe.

What medications or drugs are you taking?

Check all that apply:

☐ History of recent infection ☐ Recent fever ☐ HIV/AIDS ☐ History of stroke

If you have had a stroke, date of last stroke

Remarks and additional information

Have you ever suffered from any of these?

For each one that applies, check Past, Present, or both.

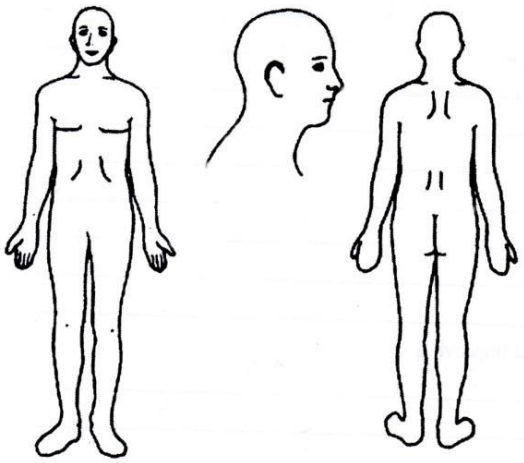
Condition	Past	Present
Corticosteroid use	☐	☐
High blood pressure	☐	☐
Dizziness or vertigo	☐	☐
Fainting	☐	☐
Frequent urination	☐	☐
Visual disturbances	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Kidney disease	☐	☐
Autoimmune disease	☐	☐
Heart attack	☐	☐
Aortic aneurysm	☐	☐
Osteoporosis	☐	☐
Prostate problems	☐	☐
Epilepsy or seizures	☐	☐
Allergies	☐	☐
Fatigue	☐	☐
Headaches	☐	☐
Migraine headaches	☐	☐
Ulcers	☐	☐
Abnormal weight gain or loss	☐	☐
Colitis or other colon problems	☐	☐
Indigestion	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Hemorrhoids	☐	☐
Bruise easily	☐	☐
Sinusitis or sinus infections	☐	☐
Depression	☐	☐
Panic attacks	☐	☐
Nausea	☐	☐
Asthma	☐	☐
Thyroid problems	☐	☐
Poor circulation	☐	☐
Anemia	☐	☐
Ringing in ears	☐	☐
Chest pain	☐	☐
Difficulty breathing	☐	☐
Hot flashes	☐	☐
Menstrual pain	☐	☐
Insomnia	☐	☐
Alcoholism	☐	☐
Drug addiction	☐	☐

Condition	Past	Present
Swelling of ankles	☐	☐
Pain in feet	☐	☐
Knee problems	☐	☐
Leg pain or sciatica	☐	☐
Scoliosis	☐	☐
Arthritis	☐	☐
Poor posture	☐	☐
Pain or stiffness: hip	☐	☐
Pain or stiffness: lower back	☐	☐
Pain or stiffness: middle back	☐	☐
Pain or stiffness: neck	☐	☐
Pain or stiffness: shoulder	☐	☐
Tingling or numbness: shoulders or arms	☐	☐
Tingling or numbness: hands	☐	☐
Tingling or numbness: hips or legs	☐	☐
Tingling or numbness: feet	☐	☐
Tingling or numbness: groin or buttocks	☐	☐

If you have arthritis, where in your body?

Where you feel pain

Mark your areas of pain on the figures, or describe them in words in the box below. Either is fine.



Describe your areas of pain, and any other comments

Payment

Payment is expected at the time of your visit.

Name of person responsible for payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment.

Please sign by hand after printing.

Patient's signature	Date

Guardian or spouse's signature authorizing care	Date