DAVID WITTWER CHIROPRACTIC, INC.
Dr. David P. Wittwer, D.C.

Name ______________________ Address ______________________

City ____________ State ______ Zip ________ Home Phone ____________ Work Phone ____________

Cell Phone (confirming apt. schedule): ____________ Carrier: ☐ Verizon ☐ ATT Wireless ☐ T-Mobile ☐ Other____________

SSN ____________ Date of Birth ________ Age _____ Height ______ Weight ______ ☐ Male ☐ Female

Would you like to be contacted via text? ☐ Yes ☐ No E-mail: ______________________

☐ Single ☐ Married ☐ Divorced Number of children: _____ Name of spouse (or parent): ______________________

Employer ______________________ Address ______________________

City ____________ State ______ Zip ________ Occupation ______________________

How were you referred to our office? ______________________

Have you ever had Chiropractic care before? ______ If yes, Dr. name? ______________ Date of last visit ________

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. ______________________ For how long? ____________

2. ______________________ For how long? ____________

3. ______________________ For how long? ____________

4. ______________________ For how long? ____________

Has this problem been getting worse or staying the same? ______________________

List other doctors consulted for these conditions: 1. ______________ 2. ______________

Have you ever had any surgeries or hospitalizations? ______ If yes, please list: ______________________

Is your condition the result of a work injury or accident? ☐ Yes ☐ No If yes, have you reported this injury to your employer? ☐ Yes ☐ No

Date of Injury: ____________ Name of person reported to: ______________ Date Reported: ____________

Are there any other activities, incidents, or events outside of work that may have caused these complaints? ______ If yes, please explain: ____________

____

Have you ever at any time in the past suffered a work injury? ☐ Yes ☐ No If yes what is the date of injury? ____________

Do you have an attorney representing you for this work injury? ☐ Yes ☐ No If yes, who is your attorney? ____________

Have you been involved in an auto accident in the last 24 months ☐ Yes ☐ No If yes, what is the date of the auto accident? ____________

Do you have an attorney representing you for this auto accident? ☐ Yes ☐ No If yes, who is your attorney? ____________

How many passengers were in the car with you? ______________________

If due to an auto accident, what is the name of your auto insurance company? ______________________

Please list any other injuries or illnesses that you have had that are not listed above: ______________________

Please indicate medications (over the counter) / prescriptions you are currently taking: ☐ Aspirin/Tylenol ☐ Pain killers ☐ Insulin ☐ Muscle Relaxers

☐ Tranquilizers ☐ Birth Control Pills ☐ Anti-Depressants ☐ Others ______________________

Health Insurance:______________ Policy #: ______________insured's Name______________

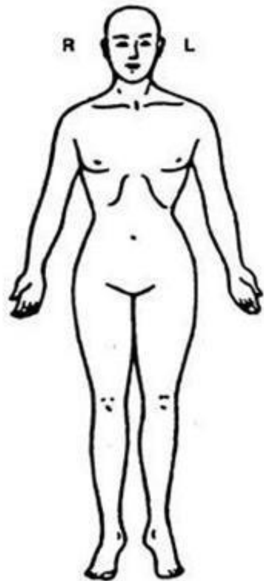
Insured's Date of Birth::____________ Are you covered by any other health insurance? ☐ Yes ☐ No, If yes please provide us with this ID card.

Do you have a Health Savings Account, Flex Spending Account, or Medical Reimbursement Account? ☐ Yes ☐ No

Patient Name: ____ Date: ________________

On the diagram below please mark the exact location of your symptoms with the letter abbreviation that most accurately describes your symptoms. Then, circle the frequency you experience the symptoms and draw a line from the frequency to the appropriate area.

Numbness = N	Tingling = T	Dull Pain = D
Sharp Pain = P	Burning - B	Stiffness = S

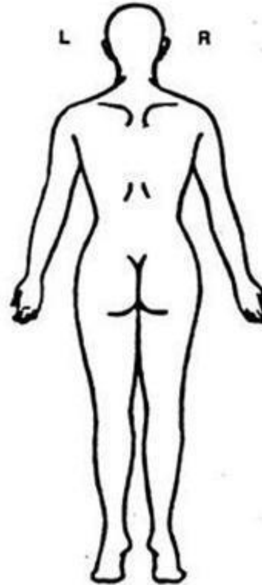


Constant
(90-100%)

Frequent
(appx 75%)

Intermittent
(appx 50%)

Occasional
(appx 25%)



Instructions: On the scale below, please circle the number that best describes the level of pain or discomfort you are feeling when your symptoms are at their worst – 0 would be no pain or discomfort at all. And 10 would be the worst possible pain.

No pain/discomfort ____ worst possible pain/discomfort

0 1 2 3 4 5 6 7 8 9 10

PREGNANCY RELEASE (women only):

This is to certify that to the best of my knowledge I am not pregnant, and David P. Wittwer, D.C. and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to unborn child.

Date of last menstrual period: ____________ ________________________ ____________

Signature date

Method of payment for today's charges: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ HSA ☐FSA ☐MEDICAL ACCOUNT ☐OTHER ________

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE THE TYPE AND LENGTH OF CARE. IF YOURE EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1) All first visit charges are payable when services are rendered.
2) The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature: ____ Date: ________________