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

Name ______________________ Address ______________________

City ______________ State ________ Zip ______________ Home Phone ______________

Cell Phone(for confirming apt schedule) ______________ Carrier: Verizon ATT Wireless T-Mobile Other __________

Email Address (for confirming apt. schedule) ______________________

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

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

Would you like to be contacted via text? Yes No Occupation: ______________

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Employer ______________________ Address ______________________

City ____________ State ______ Zip ________ Wk Phn: __________ Occupation ____________

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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: ______________

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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: __________

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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? ______________

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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 care 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

Insulin Tranquilizers Birth Control Pills Sleeping Pills Anti-Depressants Others ______________

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Health Insurance: ______________________ Policyholder: ______________

Spouse's Health: ______________________ Policyholder: ______________

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

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain, and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the five categories of daily living listed, **PLEASE INDICATE THE NUMBER THAT BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** A score of "0" means that there is no disability at all and a score of "10" means that all of the activities in which you would normally be involved have been totally disrupted, or prevented, by your health condition (pain and/or symptoms you may be experiencing).

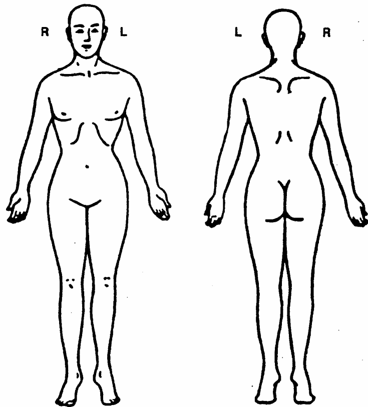
0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

1. **FAMILY/HOME RESPONSIBLITIES:** activities related to home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) __________
2. **RECREATION**: hobbies sports and other similar leisure time activities. __________
3. **SOCIAL ACTIVITY**: activities that involve participation with friends and acquaintances other than family members including parties Theater, concerts, dining out, and other social functions. __________
4. **OCCUPATION:** activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. __________
5. **SELF CARE**: activities which involve personal maintenance and independent daily living (showering, driving, getting dressed, etc) __________
6. **LIFE SUPPORT ACTIVITY**: basic life supporting behaviors such as eating, sleeping & breathing. __________

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain.

For example dull, sharp, constant, off & on, when standing, sitting, walking, etc.




**Current Complaint**

0 1 2 3 4 5 6 7 8 9 10

No Pain/Symptoms — Unbearable Pain / Symptoms

**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 an 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 TYPE OF CARE AND LENGTH OF CARE. IF YOUR 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 ______________________