SHAPERO CHIROPRACTIC

CHIROPRACTOR TO THE UNIVERSITY OF SAN FRANCISCO ATHLETIC DEPARTMENT

300 MONTGOMERY STREET – SUITE 650
SAN FRANCISCO, CA 94104
P. (415) 397-2544
F. (415) 434-1533

Who may I thank for referring you to my office?_______________________________________

Information about You

First Name_________________________________ Last Name______________________________

Home # _______________________ Cell # __________________ Work# ____________________

Address ___________________________ City _______________ State _______ Zip ___________

Email _____________________________ Age _______________ Birth Date __________________

□ widowed □ single □divorced/separated □married/partnered to (name)_______________________

Favorite hobbies or interest ____

Emergency contact _________________________________ Phone __________________________

Name of Employer ______________________________ Location/City ________________________

Information about Your Financial Responsibilities

Who is responsible for payment? ______________________________ SS# ______________________

Insurance Co. ______________________________ Group policy # ___________________________

Insured's Name ______________________________ Subscriber ID # __________________________

Signature ____________________________________ Date ____________________________________

Information about You and Chiropractic

What brought you here today? (Please check one OR both)

- □ The concern of a symptom or condition.
- □ The desire to improve your health and well-being.

Have you ever been to a chiropractor before? □ yes □ no

If yes, who were the chiropractor(s)? ____

Why did you seek chiropractic care? ____

For how long did you receive chiropractic care? □ 1-3 visits □ 4-8 visits □ <3months □ 6months □ >1yr

In your own words, what do chiropractors do? ____

____

Do you know what spinal nerve stress/subluxation is? □ yes □ no

If yes, please describe ____

What do you want to receive from your chiropractic experience here? ____________________________

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Information about your Current Health

What are your most pressing health concerns? ____

____

For how long and when did it start? ____

In your WHOLE life have you ever had a health concern in this area(s) of your body? ☐ yes ☐ no

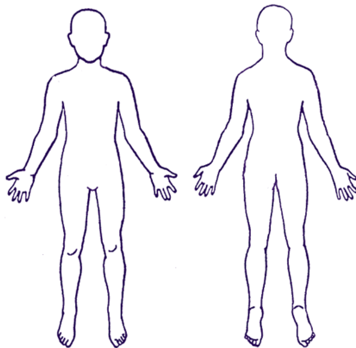
If yes, when was the first time? ____

Have you consulted any other doctor/practitioner for this health concern? ☐ yes ☐ no

If yes, please list the date, name, and credentials ______________________________

Are your health concerns... ☐ improving ☐ getting worse ☐ staying the same

What are the concerns? Please use the illustrations and lines below to explain.



Front ____

____

____

Back ____

____

____

On a scale of 1-10 (1=least, 10=most), please rate (by circling) the severity of your current symptoms

1 2 3 4 5 6 7 8 9 10

Do you have... ☐ pain ☐ numbness ☐ tingling ☐ throbbing

Is your pain... ☐ burning ☐ dull ☐ sharp ☐ shooting ☐ aching ☐ throbbing

When do you feel your pain... ☐ constantly ☐ frequently ☐ intermittently ☐ occasionally

Are your concerns affected by... ☐ standing ☐ sitting ☐ bending ☐ walking ☐ lying down ☐ weather

Do your concerns interfere with... ☐ work ☐ day-to-day activities ☐ sleep ☐ play
☐ energy levels ☐ relationships ☐ financial ☐ other

Do you mostly use your LEFT Hand/Foot or RIGHT Hand/Foot? [Please circle]

Are you currently taking any prescription medication or pain relievers for this particular concern? ☐ yes ☐ no

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Information about Your Health History

Birth and Childhood

Did you have any birth trauma? □ yes □ no □ don't know □ not sure

Do you recall any major or minor injuries as a child? □ yes □ no □ don't know □ not sure

Did you have any of the following: □ mumps □ influenza □ rheumatic fever □ smallpox □ polio □ chicken pox □ epilepsy □ whooping cough □eczema □ measles

Past injuries DO affect present health (check all boxes that apply within the course of your life)

□ moving accidents or collisions (ever)
□ falls/accidents
□ head injuries
□ sport injuries
□ broken bones
□ dislocations
□ spinal injuries
□ spinal tap
□ surgeries
□ fractures
□ wear dental appliances
□ traction
□ use(d) cane
□ extensive dental work

If yes to any of the above, please describe ______________________________

REVIEW OF SYSTEMS-WHOLE BODY

The questions below are important to build an overall picture of your physical well being to give an actual assessment for your adjustment-care. Patterns with your past and current conditions will reflect a clearer picture of your actual health.

CHECK any box that represents your past/current body area NOT FUNCTIONING 100%

□ **Head Area**
□ dizziness
□ confusion
□ headaches/migraines
□ fatigue/drained
□ vision
□ hearing
□ sinus
□ jaw area L/R
□ **Neck Area**
□ tonsillitis
□ thyroid dysfunction
□ laryngitis
□ **Shoulder Area L/R**
□ arm/hand tingling
□ tennis elbow L/R
□ cold hands

□ **Midback Area**
□ breasts/lumps
□ **Lungs**
□ breathing difficulties
□ shortness of breath
□ pneumonia
□ irritable bowel
□ colitis
□ pleurisy
□ **Stomach**
□ indigestion
□ gas/bloating
□ heartburn, acid
□ coughing
□ **Heart**
□ heart disease/stroke
□ irregular heart beat
□ abnormal blood

□ **Liver**
□ jaundice
□ anemia
□ **Gallbladder**
□ Pancreas
□ diabetes
□ **Kidney**
□ **Bladder**
□ excessive urination
□ discolored urine
□ painful urination
□ **Low Back/Pelvis**
□ leg pain/tingling
□ poor/excess appetite
□ cold feet
□ ankle swelling
□ shin splints
□ prostate pressure

□ hormonal irregularities
□ menses irregularities (PMS, heavy, painful)
□ constipation
□ hemorrhoids
□ black or bloody stools
□ **Skin Conditions** (acne, pimples, rashes)
□ **Immune System**
□ allergies
□ frequent colds, flu, sore throat, coughing
□ frequent infections
□ cancer
□ arthritis
□ sexual function
□ knee pains
□ circulation

Family History

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Please list any family health history that may concern you and their relationship to you.

____

Chemical Stressors **(work-related, nicotine, fragrances, perfume, foods, personal care products, home/car cleaning products, over-the-counter drugs)**

Would you say your conscious CHEMICAL Health is □ excellent □ okay □ poor □ don't know

Do you have any concerns in your life from past or present from chemical toxicities? □ yes □ no □ don't know

Have you ever taken any kind of antibiotics in the last year? □ yes □ no

If yes, please write down dates and the reason for medication ______________________________

Do you smoke? □ no □ Yes/ If yes, how long? _________ OR Did you use to smoke? □ Yes If yes, how long?___

Women Only: Do you take birth control pills? □ yes □ no If yes, how long?__________________

Do you take hormone replacement therapy (HRT)? □ yes □ no

Emotional Stressors **(If applicable)**

Would you say your Mental/Emotional Health is… □ excellent □ okay □ poor □ getting better □ getting worse

Do you ever feel like you have… □ depression □ weight loss/gain □ nervousness □ loss of sleep

Do you consider your job excessively stressful? □ yes □ no

Information about Your Lifestyle **PLEASE CHECK if you have had in the past or currently use any of the following:**

□ Massage/Bodywork □ Osteopathy □ Cranial Work □ Physical/Occupational Therapy □ Naturopathy □ Homeopathy
□ Herbalist □ Aromatherapy □ Acupuncture □ Reiki □ Psychotherapy/Counseling □ Nutritional Counseling
□ Allergies □ Hair Analysis □ Martial Arts □ Tai Chi □ Dance □ Yoga □ Pilate's □ Other

How many hours per week do you generally work? ______________________________

How would you describe your sleep pattern? □ excellent □ well □ restless □ not very well

Do you sleep on your… □ stomach □ back □ side

Do you wake up… □ full of energy □ feeling rested □ feeling tired □ feeling exhausted

How is your energy overall… □ full power □ okay □ low □ off/on

How HEALTHY do you feel/think your immune system is… □ strong □ okay □ low □ don't know

How would you rate your eating habits? □ excellent □ pretty good □ could be better □ needs improvement

Do you drink alcohol? ____ coffee _____ tea _____ How much water do you drink each day? ____ glasses.

The rating scale below is designed to measure the degree to which several aspects of your life are presently

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affected by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how frequently your health condition (pain and/or symptoms you may be experiencing) is present. Respond to each category by indicating the overall presence in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. A score of 0 means no presence at all and a score of 10 means that all of the activities in which you would normally be involved have been affected 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

No presence at all/ No Discomfort — Present/ Uncomfortable

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house. (Yard work, doing dishes, errands, favors for family, driving your children, etc.) ________

2. RECREATION: hobbies, sports, running, and other similar leisure time activities. ________

3. SOCIAL ACTIVITY: activities which 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 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 (taking a shower, driving, getting dressed, etc.) ________

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping and breathing ________