La Jolla Integrative Health
Dr. Rhonda Lilien, DC

Date _____

Patient Information

Patient Name _____
Last Name M First Name

Birthdate _____ Age _____ Sex M / F

Address _____

City _____ State _____ Zip _____

☐Married ☐Single ☐Minor ☐Divorced ☐Other _____

Spouse Name _____

Occupation _____

Employer/ School _____

Employer/ School Address _____

_____

Employer/ School Phone (____) _____

Primary Care Physician's Name _____

Primary Care Physician's Phone (____) _____

Whom may we thank for referring you? _____

_____

Insurance

Subscriber Name _____

Relationship to Patient _____

Insurance Co. _____

Subscriber ID # _____

Phone Numbers and Email

Home Phone (____) _____

Cell Phone (____) _____

Email address _____

Best way to contact you _____

How would you like your appointments confirmed?

☐ Email ☐ Phone ☐ Text

Emergency Contact

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Cell Phone (____) _____

Patient Condition

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low-back Pain

☐ Other _____

Date Problems Began _____

How Problem Began _____

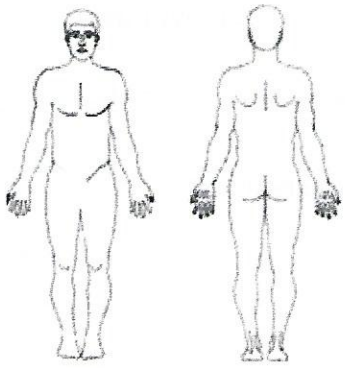
Is this condition getting progressively worse? ☐Yes ☐No ☐ Unknown

Is this … ☐ Work Related ☐ Auto Related ☐ N/A

Please mark the type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other

PLEASE MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Current complaint (how you feel today) :

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN

How often are your symptoms present? ☐ 0 - 25% ☐ 26 - 50% ☐ 51 - 75% ☐ 76 - 100%

Can you perform your daily activities? ☐Yes ☐No Describe any current limitations _____

_____

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

_____

Date of Last:

Physical Exam _____ Spinal X-Ray _____

Spinal Exam _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Epilepsy/ Seizures	☐Yes	☐No	Kidney Disease	☐Yes	☐No
Aortic Aneurysm	☐Yes	☐No	Fever Corticosteroid Use	☐Yes	☐No	Migrane Headaches	☐Yes	☐No
Anemia	☐Yes	☐No	Hernia	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Arthritis	☐Yes	☐No	Herniated Disk	☐Yes	☐No	Pacemaker	☐Yes	☐No
Birth Control Pills	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Prostate Problem	☐Yes	☐No
Cancer/ Tumor	☐Yes	☐No	History of Low Back Pain	☐Yes	☐No	Recent Infection	☐Yes	☐No
Diabetes	☐Yes	☐No	History of Neck Pain	☐Yes	☐No	Recent Trauma	☐Yes	☐No
Dizzyness/ Fainting	☐Yes	☐No	History of Mid Back Pain	☐Yes	☐No	Visual Disturbances	☐Yes	☐No

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/ Stroke

Exercise	**Work Activity**	**Habits**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/ Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Are you pregnant? ☐Yes ☐No Due Date _____

Surgeries you have had:

	Description	Date
	_____	_____
	_____	_____
	_____	_____

Medications	**Allergies**	**Vitamins / Herbs / Minerals**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____