



19712 MacArthur Blvd. Suite 100  
Irvine, CA 92612  
Phone: (949) 229.7655

Today's Date \_\_\_\_\_

**PERSONAL DATA**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Both Parent's names (if you are under 18) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Carrier \_\_\_\_\_ SS# \_\_\_\_\_

E-mail address \_\_\_\_\_ @ \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status  S  M  D  W  L/W Spouse/Partner \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**REASON FOR SEEKING CHIROPRACTIC CARE**

What concerns do you feel Carmona Chiropractic can address for you? \_\_\_\_\_

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

Explain: \_\_\_\_\_

**HEALTH CARE PRACTITIONER HISTORY**

Have you ever received Chiropractic care?  Y  N Name of D.C. \_\_\_\_\_

How long under care?  \_\_\_\_\_ days  \_\_\_\_\_ weeks  \_\_\_\_\_ months  \_\_\_\_\_ years

Date of last visit: \_\_\_\_\_ Why did you stop care? \_\_\_\_\_

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

Medical Physician  Naturopath  Acupuncturist  Homeopath

Massage Therapist  Psychotherapist  Energy Healer  Dentist

Reason: \_\_\_\_\_

The primary system in the body which coordinates health is the NERVE SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION. VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment. Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused Vertebral Subluxations to occur.

## FOR WOMAN

Are you pregnant?    Y        N        Date of last menstrual period: \_\_\_\_\_

If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If **pregnant**, Due Date: \_\_\_\_\_ Name of OBGYN or Midwife \_\_\_\_\_

Where will you be birthing your baby?    Hospital    Home    Birthing Center    Other \_\_\_\_\_

## PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

- Home         Natural         Hospital         Caesarian section         Forceps  
 Breech         Cord around neck         Prolonged labor         Drug induced labor         Suction

## PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list.

Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? (Check all that apply)

- Automobile    Motorcycle    Bicycle         Sports         Playground    Abuse

If yes, state type of injury and date:

\_\_\_\_\_

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)?     Y                       N

If yes, list body parts injured and dates of injuries:

\_\_\_\_\_

Have you ever been hospitalized or had surgery?     Y                       N

If yes, state reason and dates: \_\_\_\_\_

## EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents' divorce	Y	N	Illness	Y	N

## CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated?  Y  N If yes, did you have a reaction?  Y  N  Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

Toxic chemicals  Second hand smoke  Drug therapy  
 Radiation  Chemotherapy  Other

If yes, please list: \_\_\_\_\_

Do you have allergies or sensitivities to any foods?  Y  N

If yes, please list: \_\_\_\_\_

Do you presently consume any of the following?

Coffee/caffeine  Alcohol  Tobacco  Over the counter drugs  Prescribed drugs

Please list all medications (prescribed and over the counter): \_\_\_\_\_

\_\_\_\_\_

**Note: It is imperative that you list all medications as they may have an influence on your care.**

## QUALITY OF LIFE (presently)

How do you grade your physical health?  Good  Fair  Poor

How do you grade your emotional/mental health?  Good  Fair  Poor

How do you rate your overall "quality of life"?  Good  Fair  Poor

Do you exercise regularly? If yes, how often? \_\_\_\_\_

Do you take supplements? If yes, please list: \_\_\_\_\_

Do you follow a special dietary regime? \_\_\_\_\_

## YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

- Relief of a symptom or problem
- Relief and Prevention of a symptom or problem
- Healthier spine and nerve system
- Optimal health
- OTHER \_\_\_\_\_

## INSURANCE INFORMATION:

Subscriber: \_\_\_\_\_ Insurance Co: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_ Member ID #: \_\_\_\_\_  
Group #: \_\_\_\_\_

### PLEASE READ AND SIGN

1. I consent to receive communication from Dr. Heather Carmona, D.C. via email, postal mail, text and telephone messaging in connection with my care.  Yes  No If I should withdraw my consent, I will notify the office in writing.
2. I have been informed of the Carmona Chiropractic "Notice of Privacy Practices for Protected Health Information (HIPAA)" information.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Heather Carmona, D.C. permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature of Parent (for minor): \_\_\_\_\_ Date: \_\_\_\_\_

*Thank you for choosing Dr. Heather Carmona, DC  
I look forward to helping you.*

24-Hour Cancellation/Rescheduled Policies of Appointment

24-hour advance notice is required when cancelling or rescheduling a Chiropractic appointment. If you are unable to give us at least 24 hours advance notice you will be charged \$50 for your missed Chiropractic appointment. You will received a courtesy appointment reminder via automated text and/or email, but please know this is a courtesy and should plan accordingly for your appointment. Thank you for your understanding.

“I have read, understand and agree to the provisions of this policy.”

---

PATIENT NAME

---

PATIENT SIGNATURE/GUARDIAN