Sierra Spine & Fitness

582 Searls Avenue Nevada City, CA 95959 (530) 470-8500

Welcome to Sierra Spine & Fitness. Please fill out the following form so that I may better serve you.

First Name:_____ MI_____Last Name:_____Sex Assigned at Birth_____
Current Gender Identity_____

Mailing Address_____ City_____ State_____ Zip_____

H. Phone(_____)_____W. Phone(_____)_____ Cell Phone(_____)_____

Email_____

Date of Birth_____Age_____ Married? Y N Spouse_____

Referred by_____Social Security #_____

Occupation_____ Employer_____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

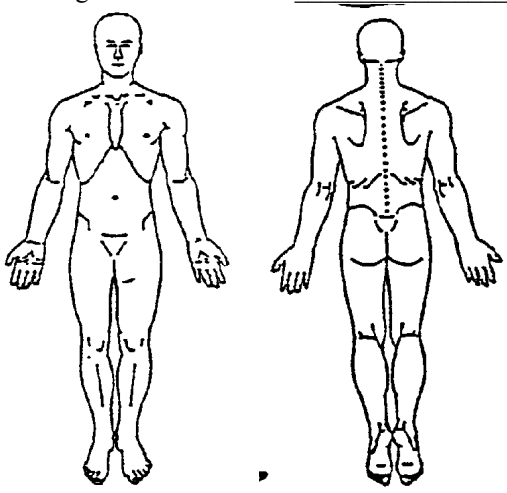
Reason I am seeking chiropractic care:

_____

_____

_____

Complaint Began when and how? _____



Please mark the pictures at left with "X""s to indicate the area(s) of your complaint.

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

……..…over please……

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature _____ Date _____

Parent or Guardian Signature if Under 18: *I give Dr. Roberts my consent to treat my child,*

Signature_____ _____ Date _____

Print Name_____