BodyCare Clinic

1735 Spruce St. Suite D Riverside CA

951-680-9685

Patient History Information Form

Name: Date:

Address: City: State: Zip:

Phone numbers Home: Work: Cellular:

EMAIL:

Age: Date of Birth: Gender: No. Children

Occupation: Employer: Years Employed:

Employers Address: City: State: Phone:

Spouse's Name: Occupation: Employer:

What is your major complaint?

Other Complaints:

How long have you had this condition? Have you had this similar condition in the past?

What activities aggravate your condition?

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and Goes ☐

Is this condition interfering with: Work ☐ Sleep ☐ Daily Routine ☐ Other ☐

How long has it been since you really felt good?

List surgical operations:

Are you taking any medications? What kind?

Any non-prescription drugs? What kind?

Any vitamins? What kind?

OTHER DOCTORS SEEN FOR THIS CONDITION: MD ☐ DC ☐ DO ☐ DDS ☐

Doctor's Name: Diagnosis:

X-rays: MRI/CAT Scan : Blood Test: Other:

Treatment: Medication: Physiotherapy:

Results: Length of time under care:

Were you off work? If so how long: Have you returned to your same job?

If not, why?

CHECK ANY OF THE FOLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Chicken Pox	☐ Goiter	☐ Mental Disorder	☐ Rheumatic Fever
☐ Anemia	☐ Diabetes	☐ Heart Disease	☐ Mumps	☐ Scarlet Fever
☐ Appendicitis	☐ Diphtheria	☐ Influenza	☐ Pleurisy	☐ Scoliosis
☐ Arthritis	☐ Eczema	☐ Kidney Stones	☐ Pneumonia	☐ Tuberculosis
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Polio	☐ Venereal Infection

Person responsible for this account: Referred by:

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature Date: