Welcome To AV Chiropractic Health Center, Dr. Rick Duenas
44820 10th Street West, Lancaster, CA 93534
Phone: (661) 940-6302 * Fax (661) 940-6083

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient Information

Patient Name ______________________________
Today's Date ______________ Date of Birth ______________
Social Security # ______________________________
Address ______________________________
City ______________________________
State ______________________ Zip ______________
Gender: ❒ Male ❒ Female Height _______ Weight _______
❒ Single ❒ Married ❒ Partnered ❒ Engaged
❒ Separated ❒ Divorced ❒ Widowed ❒ Minor
How many children do you have? ______________
Please list any family members being treated here ______________
____
Occupation ______________________________
Employer/School ______________________________
Employer/School Address ______________________________
____
Employer/School phone #: (_____) ______________

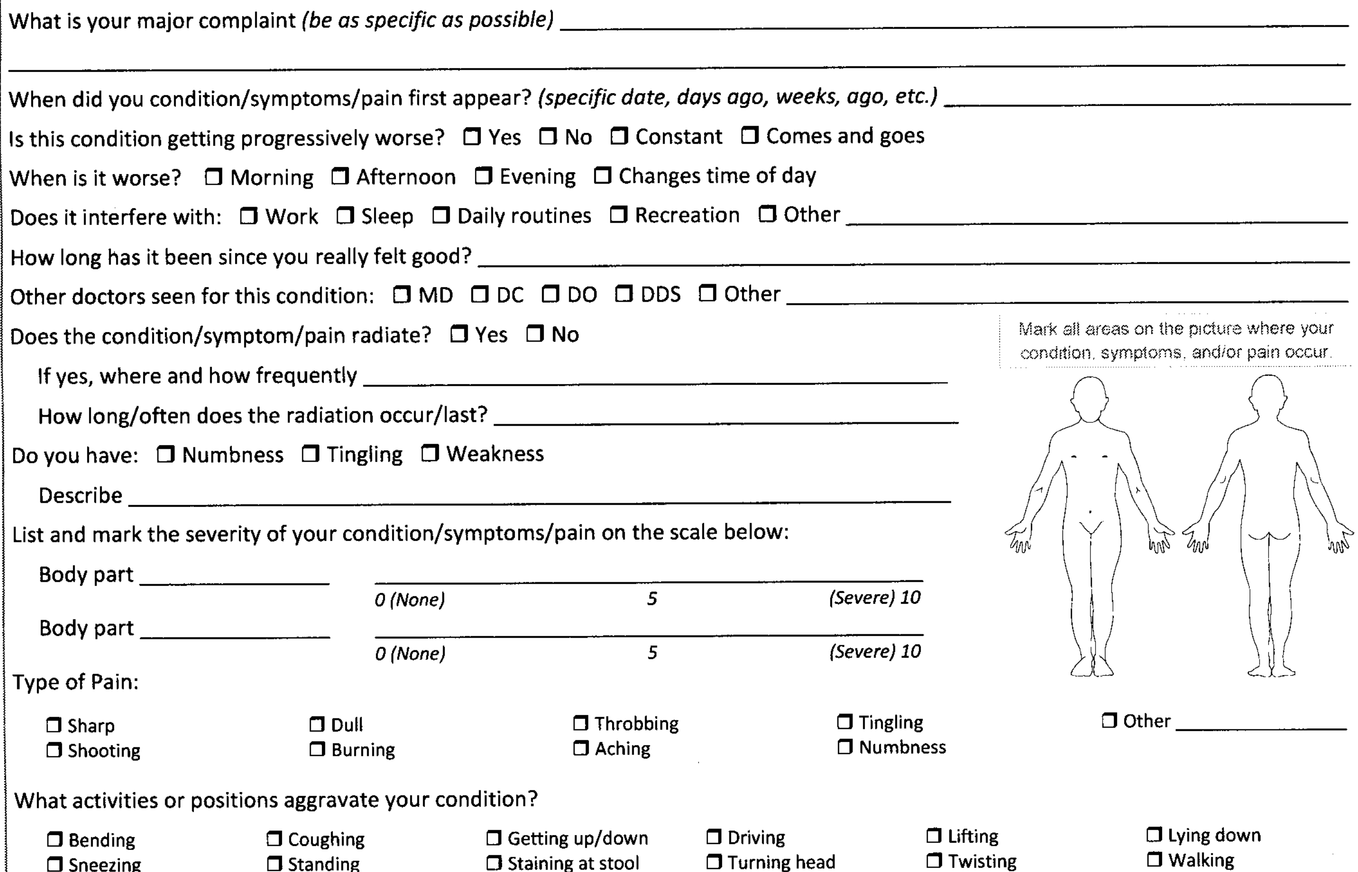
Contact Information

Home Phone (______) ______________________________
Cell Phone (______) ______________________________
Email address ______________________________
May we contact you via (please check for all applicable):
❒ Home phone ❒ Cell ❒ Work phone ❒ Email

In case of emergency please contact:
Name ______________________________
Relationship ______________________________
Home Phone (______) ______________________________
Alternate Phone (______) ______________________________

Spouse's/Partner's name ______________________________
Spouse's/Partner's employer ______________________________

Who referred you? ______________________________



Patient Condition

What is your major complaint *(be as specific as possible)* ______________________________
____
When did you condition/symptoms/pain first appear? *(specific date, days ago, weeks, ago, etc.)* ______________
Is this condition getting progressively worse? ❒ Yes ❒ No ❒ Constant ❒ Comes and goes
When is it worse? ❒ Morning ❒ Afternoon ❒ Evening ❒ Changes time of day
Does it interfere with: ❒ Work ❒ Sleep ❒ Daily routines ❒ Recreation ❒ Other ______________
How long has it been since you really felt good? ______________
Other doctors seen for this condition: ❒ MD ❒ DC ❒ DO ❒ DDS ❒ Other ______________
Does the condition/symptom/pain radiate? ❒ Yes ❒ No
If yes, where and how frequently ______________
How long/often does the radiation occur/last? ______________
Do you have: ❒ Numbness ❒ Tingling ❒ Weakness
Describe ______________________________
List and mark the severity of your condition/symptoms/pain on the scale below:

Body part ______________ *0 (None)* 5 *(Severe) 10*

Body part ______________ *0 (None)* 5 *(Severe) 10*

Mark all areas on the picture where your condition, symptoms, and/or pain occur.

Type of Pain:

❒ Sharp ❒ Dull ❒ Throbbing ❒ Tingling ❒ Other ______________
❒ Shooting ❒ Burning ❒ Aching ❒ Numbness

What activities or positions aggravate your condition?

❒ Bending ❒ Coughing ❒ Getting up/down ❒ Driving ❒ Lifting ❒ Lying down
❒ Sneezing ❒ Standing ❒ Staining at stool ❒ Turning head ❒ Twisting ❒ Walking

Patient Condition

What activities or positions relieve your condition:

❒ Heat ❒ Lying down ❒ Sitting ❒ Sitting ❒ Stretching ❒ Other
❒ Ice ❒ Medication ❒ Massage ❒ Standing ❒ Exercise

Have you ever had this condition before? ❒ Yes ❒ No If yes, when? ______

Were you treated for this condition or a similar one before? ❒ Yes ❒ No If yes, when/by whom? ______

______

Health History

Do you have any allergies? (food, contact, environmental) ______

List any vitamins, herbs and supplements ______

When was your last: Physical examination ______ Blood/lab work ______ X-ray study ______

Injuries/Surgeries you've had and when? ______

______

Have you had or do you have any of the following conditions or diseases? ***Please check any that apply to indicate yes***

❒ AD/HD
❒ Adrenal disorder
❒ Anxiety
❒ Arthritis
❒ Asthma
❒ Autoimmune disorder: ______
❒ Bleeding disorder
❒ Blurred vision
❒ Bowel/Bladder problems
❒ Buzzing in ear
❒ Cancer - type? ______
❒ Carpal tunnel syndrome
❒ Celiac disease (gluten)
❒ Chest pains
❒ Chronic fatigue
❒ Cold hands or feet
❒ Colitis/diverticulitis
❒ Compression fractures
❒ Connective tissue issues
❒ COPD
❒ Depression
❒ Diabetes
❒ Digestive/bowel problems
❒ Dizziness or vertigo
❒ Ear infections
❒ Fibromyalgia
❒ Food sensitivity
❒ Fusions (spinal, joint)
❒ Gout
❒ Gall Bladder issue
❒ Immune compromise
❒ Heart disease
❒ Hepatitis (A, B, C, etc.)
❒ Herpes
❒ High blood pressure
❒ Hip replacement
❒ HIV/AIDS
❒ Kidney disease
❒ Knee surgery
❒ Liver disease
❒ Marfan's syndrome
❒ Multiple sclerosis
❒ Osteoporosis/penia
❒ Parkinson's disease
❒ Rotator cuff problem
❒ STI/STD
❒ Shoulder surgery
❒ Spinal surgery
❒ Stroke/TIA
❒ Thyroid problems
❒ Tuberculosis
❒ Other ______
❒ Other ______

Are there any conditions that run in your family? ❒ Yes ❒ No If yes, what condition(s) and which family member? ______

______

Personal and Social Health History

Are you currently pregnant, or do you think you may be pregnant? ❒ Yes ❒ No If yes, how many weeks? ______

How many hours per week do you typically work/attend school? ❒ <20 hrs ❒ 20 hrs ❒ 30 hrs ❒ 40 hrs ❒ 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc.)? ______

Do you exercise? ❒ Yes ❒ No If yes, how often and what type? ______

How would you rate your eating habits? ❒ Excellent ❒ Pretty good ❒ Could be better ❒ Needs improvement

How well do you sleep? ❒ Excellent ❒ Pretty good ❒ Restless ❒ Can't sleep ❒ Wake up often

How many hours of sleep do you get daily? ______ hours *and* Do you feel rested in the morning? ❒ Yes ❒ No

How is your energy overall? ❒ Full power ❒ OK ❒ Low ❒ Sporadic/Generally fatigued ❒ I depend on caffeine for energy

How often do you get 'sick'? ❒ almost never ❒ I tend to catch what is going around ❒ I'm constantly sick

What do you hope to receive from our program? ______

Thank you for completing our health care questionnaire

My Current Diet

Name: ______________________________ Date: ___/___/___

List your diet on an average day below. Don't worry about trying to impress us by telling the doctor what you think he wants to hear. Just think about how you eat on an average day.

Check all the meals that you eat each day (check all that apply):

___ Breakfast ___Snack ___ Lunch ___Snack ___Dinner ___Snack

A typical breakfast consists of ______________________________

____

A typical lunch consists of ______________________________

____

A typical dinner consists of ______________________________

____

A typical snack between meals consists of ______________________________

____

How much water to you drink/day?

Do you drink green/black tea?

Do you drink herbal tea? YES / NO What is it the tea? ______________________________

How much coffee do you drink /day?

How much soda pop do you drink/day?

List any known food sensitivities or allergies: ______________________________

List the foods that you crave: ______________________________

My Surgical History

List the type of surgery, reason for the surgery and year performed. (ie: left breast surgery for cancer in 2004)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Medications

Name ______________________________________ Date ___/___/___

List the name of each current prescribed and over the counter medications, its prescribed use and any side-effects/reactions/positive responses. (example of use: BCP - birth control pills can be used to prevent pregnancy, manage menopause or acne, etc.). (example of side-effect could be Tylenol caused liver enzymes to increase).

	Medication	Prescribed Use	Side-effects
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

AV CHIROPRACTIC HEALTH CENTER

Name: ______________________________ Date: ______________

Please take several minutes to answer these questions.

1. How have you taken care of your health in the past?

    a. Medications
    b. Emergency Room
    c. Routine Medical
    d. Exercise
    e. Nutrition/Diet
    f. Holistic Care
    g. Vitamins
    h. Chiropractic
    i. Other (please specify): ________________

2. How did the previous method(s) work out for you?

    a. Bad results
    b. Some results
    c. Great results
    d. Nothing changed
    e. Did not get worse
    f. Did not work very long
    g. Still trying
    h. Confused

3. How have others been affected by your health condition?

    a. No one is affected
    b. Haven't noticed any problem
    c. They tell me to do something
    d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

    a. Job
    b. Kids
    c. Future ability
    d. Marriage
    e. Self-esteem
    f. Sleep
    g. Time
    h. Finances
    i. Freedom

5. Are there health conditions you are afraid this might turn into?

    a. Family health problems
    b. Heart disease
    c. Cancer
    d. Diabetes
    e. Arthritis
    f. Fibromyalgia
    g. Depression
    h. Chronic Fatigue
    i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities?

Please give examples:____

____

What has that cost you ? (time, money, happiness, freedom, sleep, promotion, etc.)
Give 3 examples:

1) ____
2) ____
3) ____

What are you most concerned with regarding your problem? ______________________

____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

Please be specific ____

____

What would be different/better without this problem? Please be specific ________________

____

What do you desire most to get from working with us?____________________________

____

What is that worth to you? ____

____