Hwang Family Chiropractic Corporation
a wellness evolution

995 Montague Expressway, Suite 211, Milpitas, CA 95035
www.hwangwellness.com (408) 946-4151

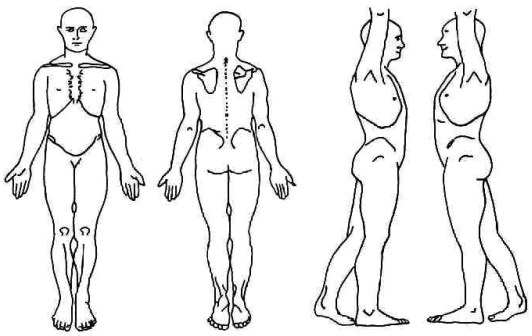
CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION

First Name Last Name	☐ Male ☐Female Date / /
Address	Email
City State Zip	Cell Phone ( ) - Other Phone ( ) -
Date of birth / / Age	Height (Feet & Inches) Weight (Pounds)
Marital status ☐Single ☐Married ☐ Divorced ☐ Widowed	Pregnant ☐ Yes ☐ No Number of children
Occupation	Social Security Number
Employer's Name	Driver's license Number
Employer's Address	Spouse/ Guardian Name
*If nature of injury is an auto accident, please provide auto insurance information below. Otherwise please skip to "**REASON FOR VISIT**" Auto Insurance Company Name	Spouse's Occupation/ Employer
Auto Insurance Contact Person	Spouse's Health Status
Auto Insurance Phone ( ) -	Emergency Contact Person Phone ( ) -
Auto Insurance Claim Number	**Who may we Thank for referring you to our Clinic**

REASON FOR VISIT

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History". Using the below body charts, please circle all affected areas.



List main complaint according to their severity	Rate severity 1=mild 10=worst	When did this condition start?	Was this condition caused by injury?
1.			
2.			
3.			
4.			

Are these conditions interfering with any of the following:

☐**Daily routine**	☐**Work**	☐ **Sleep**	☐**Sports/Exercise**	☐**Hobbies**

What kind of pain you are experiencing: ☐ Sharp ☐ Dull ☐ Travels ☐ Comes and Goes ☐ Constant

Since the problem started, it is: ☐ About the same ☐ Getting better ☐ Getting worse

What made your condition better? _____ What made your condition worse? _____

Do you have a family history of this complaints or similar symptoms: _____

PLEASE TURN OVER >

Other doctors you have seen for this condition:

☐ **"Limited Scope" Chiropractor (focuses mainly on neck and back pain)**
☐ **"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)**

Medical Doctor _____ When did you see them? _____ What did they say was wrong? _____
Other _____ When did you see them? _____ What did they say was wrong? _____

Have you ever had x-rays or MRI taken? Area of body:_____ When?_____ Where?_____

PAST HEALTH HISTORY

Please mark the following conditions you may have had or have now:

☐ADD/ADHD	☐Constipation/Diarrhea	☐Headache/Migraines	☐Menstrual Pain	☐Skin Irritations/Eczema
☐Allergy	☐Cold Hands/Feet	☐Heartburn	☐Neck Stiff/Pain	☐Sleeping Problems
☐Asthma	☐Depression	☐High Blood Pressure	☐Nervousness	☐Stomach Upset
☐Arthritis	☐Dizziness	☐Irregular Periods	☐Numbness in Fingers/Toes	☐Tension
☐ Autism	☐Erectile Dysfunction	☐Irritable Bowel Syndrome	☐Pain/Needles in Arms/Legs	☐Thyroid Problems
☐ Back Pain/Stiff	☐Fainting	☐Loss of Balance	☐Ringing in Ears	☐Ulcers
☐ Bloating	☐Fatigue	☐Loss of Smell/Taste	☐Sinus Problems	☐Urinating Problems

GENERAL HEALTH HISTORY

Because accumulation of stress affects your overall health and ability to heal please pay close attention to this as it will help us help you!

1. **Physical stress (falls, accidents, work postures, surgery, etc.)** _____

   How do you grade your physical health? ☐**Excellent** ☐**Good** ☐**Fair** ☐**Poor** ☐**Getting worse**

2. **Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)** _____

   How do you grade your dietary health? ☐**Excellent** ☐**Good** ☐**Fair** ☐**Poor** ☐**Getting worse**

3. **Psychological stress (work, relationships, finances, self-esteem, etc.)** _____

   How do you grade your emotional/ mental health? ☐**Excellent** ☐**Good** ☐**Fair** ☐**Poor** ☐**Getting worse**

WHICH WAY DO YOU WANT TO GO……

On a Scale of 0-10 please rate how important health is to you: _____

On a Scale of 0-100 please describe your present level of health:

☐**Excellent (90-100)**	☐**Good (80-89)**	☐**Transition (70-79)**	☐**Challenged (60-69)**	☐**Very challenged (0-59)**

On a scale of 0-100 please describe what level of health do you want to achieve:

☐**Excellent (90-100)**	☐**Good (80-89)** ☐	☐**Transition (70-79)**	☐**Challenged (60-69)**	☐**Very challenged (0-59)**

I consent to a professional and complete chiropractic examination and any radiographic examination that the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

_____ _____ _____
Print Patient/Child Name Patient's/ Parent's/ Guardian's Signature Date