Bloch Chiropractic Wellness & Sports Medicine

6324 E Pacific Coast Highway, Ste C, Long Beach, CA 90803

Phone: (562) 493-5600

Patient Information

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name : _____ Last Name: _____

Sex (circle): M F Height: _____ Weight: _____

Marital Status (circle): Yes No Spouses Name: _____ # of Children: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

Email: _____

Referral Information

Referring Physician: _____ Referred Patient: _____ Referred By: _____

Advertisement (circle): Yes No Advertisement: _____

Directory (circle): Yes No Referred Directory: _____

Employer Information

Employed (circle): Full Time Part Time Homemaker Unemployed Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Insurance Information

Payment (circle): Personal 3rd Party Self Pay

Resp. for Payment: _____ Responsible Phone: _____

Payment Name: _____ Primary Phone #: _____ Primary ID/Policy: _____

Payment Address: _____

Payment City: _____ Payment State: _____ Payment Zip: _____

Primary Group #: _____ Primary Name: _____ Primary DOB: _____

Second Name: _____ Second Phone #: _____ Second ID/Policy: _____

Second Address:_____

Second City: _____ Second State: _____ Second Zip: _____

Second Group #: _____ Second Name: _____ Second DOB: _____

Claim #: _____ Claim Contact: _____ Claim Phone #: _____

Attourney Name: _____ Attourney Phone #:_____

Patient Name: _____

History

Last Physical Exam: _____ Physician Name: _____ Physician Phone #: _____

Physician City: _____ Physician State: _____ Physician Zip Code: _____

Health Conditions:_____

Previous Chiro Care: Yes No Date: _____ Explain: _____

Chance Pregnant: Yes No Planning: Yes No

Medications: _____

Supplements: _____

Broken Bones: Yes No Treatment: Yes No Explain: _____

Sprains/Strains: Yes No Treatment: Yes No Explain: _____

Hospitalized: Yes No Explain: _____

Surgery: Yes No Explain: _____

Auto Accident: Yes No Treatment: Yes No Explain: _____

Struck Unconcious: Yes No Treatment: Yes No Explain: _____

Eating Disorder: Yes No Explain: _____

Stroke: Yes No Explain: _____

Family Health History: _____

Complaint Information

Injury Occurred (circle): Auto Accident Work 3rd Party Other Injury Date: _____

Injury Origin: _____

Describe Discomfort: _____

Frequency (circle): Always Hourly Daily Occasionally

Interere with Activities: Yes No Affected Sleep: Yes No

Missed Work: Yes No Unable to Work from: Unable to Work til:

Affected Appetite: Yes No Explain: _____

Reduced Work: Yes No Explain: _____

Does it Worsen: Yes No Explain: _____

Weather Affects it: Yes No Explain: _____

Aggrevates Condition: _____

Improves Condition: _____

Received Treatment: Yes No Explain: _____

X-Rays Taken: Yes No Explain: _____

Same Condition Before: Yes No Date: _____ Practitioner: _____