BodyCare Clinic
1735 Spruce St. Suite D Riverside CA
951-680-9685

Patient History Information Form

Name:			Date: 10/02/2024
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:

IMPORTANT: Please check all present symptoms

HEAD:
- ☐Headache
  - ☐Sinus (allergy)
  - ☐Entire head
  - ☐Back of head
  - ☐Forehead
  - ☐Temples
  - ☐Migraine
- ☐Head feels heavy
- ☐Loss of memory
- ☐Light headedness
- ☐Fainting
- ☐Light bothers eyes
- ☐Blurred vision
- ☐Double vision
- ☐Loss of vision
- ☐Dizziness
- ☐Loss of hearing
- ☐Pain in ears
- ☐Ringing in ears
- ☐Buzzing in ears

NECK:
- ☐Pain in neck
- ☐Neck pain with movement
  - ☐Forward
  - ☐Backward
  - ☐Turn to left
  - ☐Turn to right
  - ☐Bend to right
  - ☐Bend to left
- ☐Pinched nerve in neck
- ☐Neck feels out of place
- ☐Muscle spasms in neck
- ☐Grinding sounds in neck
- ☐Arthritis in neck

SHOULDERS:
- ☐Pain in shoulder joints ☐R ☐L
- ☐Pain across shoulders
- ☐Bursitis ☐R ☐L
- ☐Arthritis ☐R ☐L
- ☐Can't raise arm
  - ☐To shoulder level
  - ☐Over head
- ☐Tension in shoulders
- ☐Pinched nerve in shoulder ☐R ☐L
- ☐Muscle spasms in shoulder ☐R ☐L

ARMS & HANDS:
- ☐Pain in arm ☐R ☐L
- ☐Pain in elbow ☐R ☐L
- ☐Pain in forearm ☐R ☐L
- ☐Pain in hands ☐R ☐L
- ☐Pain in fingers ☐R ☐L
- ☐Sensation of pins & needles in arms ☐R ☐L
- ☐Sensation of pins & needles in fingers ☐R ☐L
- ☐Numbness in arms ☐R ☐L
- ☐Numbness in fingers ☐R ☐L
- ☐Fingers go to sleep ☐R ☐L
- ☐Hands cold ☐R ☐L
- ☐Swollen joints in fingers ☐R ☐L
- ☐Sore joints in fingers ☐R ☐L
- ☐Arthritis in fingers ☐R ☐L
- ☐Loss of grip strength ☐R ☐L

MID-BACK:
- ☐Mid-back pain
- ☐Mid-back feels out of place
- ☐Pain from front to back through sternum
- ☐Pain between shoulders
- ☐Muscle spasms
- ☐Pain in kidney area

CHEST:
- ☐Chest pain
- ☐Shortness of breath
- ☐Pain around ribs ☐R ☐L
- ☐Breast pain
- ☐Dimpled or orange peel breast
- ☐Irregular heartbeat

ABDOMEN:
- ☐Nervous stomach
- ☐Foods can't eat:_____
- ☐Nausea
- ☐Gas
  - ☐Burping
  - ☐Flatulence
- ☐Constipation
- ☐Diarrhea
- ☐Hemorrhoids

LOW BACK:
- ☐Low back pain
  - ☐Upper low back
  - ☐Lower low back-waist
  - ☐Sacroiliac/buttock

Low back pain is worse when:
- ☐Bending
- ☐Coughing
- ☐Lifting
- ☐Lying Down (sleeping)
- ☐Sitting
- ☐Standing
- ☐Walking

- ☐Pain relieved when:_____
- ☐Low back feels out of place
- ☐Muscle spasms
- ☐Arthritis

HIPS, LEGS & FEET:
- ☐Pain in buttocks ☐R ☐L
- ☐Pain in hip joint ☐R ☐L
- ☐Pain down leg ☐R ☐L
- ☐Knee pain ☐R ☐L
  - ☐Inside
  - ☐Outside
- ☐Leg cramps ☐R ☐L
- ☐Cramps in feet ☐R ☐L
- ☐Pins & needles in legs ☐R ☐L
- ☐Numbness in legs ☐R ☐L
- ☐Pins & needles in feet ☐R ☐L
- ☐Feet feel cold ☐R ☐L
- ☐Swollen ankles ☐R ☐L
- ☐Swollen feet ☐R ☐L

WOMEN ONLY:
- ☐Menstruation pain
- ☐Cramping
- ☐Irregularity
- ☐Cycle_____days
- ☐Birth control_____(type)
- ☐Hysterectomy
- ☐Genital cancer
- ☐Discharge
- ☐Menopause
- ☐Tumors
- ☐Abortions
- ☐Are you or do you think you are pregnant?

MEN ONLY:
- ☐Urinary frequency
- ☐Difficulty in starting urine flow
- ☐Night urination
  Number of times urinate/night_____
- ☐Prostate pain/swelling

GENERAL:
- ☐Nervousness
- ☐Irritable
- ☐Depressed
- ☐Fatigue
- ☐Generally feel run down
- ☐Normal sleep_____hrs.
- ☐Loss of sleep_____hrs. per night
- ☐Gain weight_____lbs.
- ☐Coffee_____cups per day
- ☐Tea_____cups per day
- ☐Other caffeine beverage_____
- ☐Cigarettes_____packs per day
- ☐Diabetes
- ☐Hypoglycemia/low blood sugar

HEALTH HABITS:

Sleeping posture:
- ☐Back
- ☐Side
- ☐Stomach

EXERCISE REGIMES:
- ☐Aerobics Class
- ☐Bicycle/stationary bike
- ☐Gardening/yard work
- ☐Walk/treadmill/stair/running
- ☐Weight class
- ☐Yoga
- ☐Other_____

EXERCISE FREQUENCY:
- ☐None
- ☐Daily
- ☐1-2 times per week
- ☐3 or more times per week