Concierge Mobile Chiropractic
Dr. Neda Nafei, Chiropractor
California License #:21446
1860 Mowry Ave Suite 303
Fremont, Ca 94538
(510) 791-6332
(925) 880-BACK

Chiropractic ~ Health History

Name (please print):_____Date:_____
Address:_____ City:_____ State: _____ Zip: _____
E-mail Address: _____

Birth Date: _____ Age _____ SS# _____

Height _____ Weight_____
Home Phone: _____ Work Phone: _____
Name of Employer _____ Occupation: _____
Marital Status: S M D W # of children: _____
Spouse/Partner Name _____ Spouse/Partner Age _____

Financial Information: Who is responsible for this account?_____

Reason Seeking Care: Pain/Injury Related YES NO Wellness/Health Maintenance YES NO

Accidents: Please list other accidents, include dates. (car, bicycle, motorcycle, sports, falls at work or home)

_____
_____
_____

Surgeries/Conditions: Please list major surgeries, broken bones or conditions, include dates.

_____
_____
_____

Medications: Please list prescription & over-the-counter medications you are currently taking & their purpose.

_____
_____
_____
_____
_____

Have you been to a chiropractor before? YES NO
Briefly describe that experience:

_____
_____
_____

Did the last chiropractor adjust your spine? YES NO
If yes, was there a "popping" sound when they adjusted you? YES NO
If yes please explain to the best of your ability what causes that "popping" sound:

_____
_____
_____

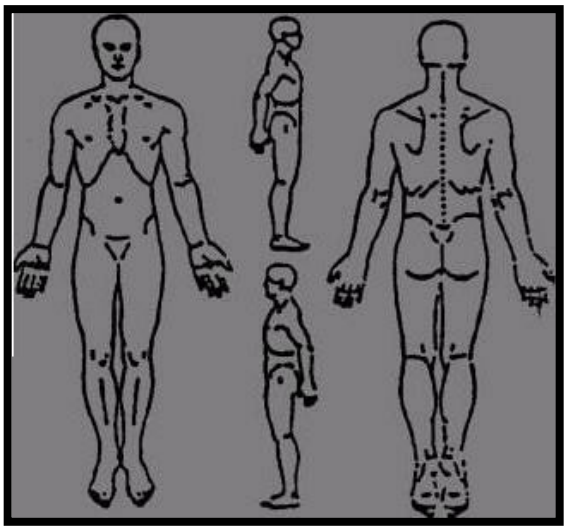
Expectations of care. How many visits to our office do you anticipate? _____

If you are here due to an injury or pain, please describe what happened:

_____
_____
_____

Please mark your areas of pain on the figures by indicating the appropriate location of pain and the symbol that best describes your discomfort.

Sharp & Stabbing	A
Dull & Achy	B
Pins & Needles	C
Numbness	D
Temperature Change	E



Please score all of the following on a scale of 1-10, based on your current condition.

Pain: 1=no pain, 10=worst pain you have ever had

_____

Personal care: (washing, dressing, etc.)
1=I can take care of myself with no extra pain, 10=I can't take care of myself at all _____

Lifting: 1=I can lift with no extra pain, 10=I can't lift at all due to _____
Reading: 1=I can read with no extra pain, 10= I can't read at all due to pain _____
Headaches: 1=no headaches, 10=worst headaches I have ever had _____
Concentration: 1=I can concentrate fully, 10=I can't concentrate at all _____
Work: 1=I can work as much as I want, 10=I can't work at all _____
Driving: 1=I can drive with no pain, 10=I can't drive due to pain _____
Sleeping: 1=I sleep fine, 10=I can't sleep at all _____

If you CAN POSSIBLY answer YES, circle YES If you MUST answer NO, circle NO
Please answer all questions. If you are not sure do your best.

Has your eyesight blacked out completely?……...	YES	NO
Have you fainted more than twice in your life?	YES	NO
Were you ever knocked unconscious?.....	YES	NO
Are you hard of hearing?	YES	NO
Do you have allergies?…….....YES		NO
Have you ever coughed up blood?	YES	NO
Have you suffered frequent cramps in your legs? …….....	YES	NO
Has a doctor ever said you had heart problems?	YES	NO
Has a doctor ever said you had ulcers?.....	YES	NO
Does pressure or pain in your head often make life miserable?	YES	NO
Have you or a family member ever had convulsions or epilepsy? Who?.....YES		NO
Did a doctor ever treat you for a tumor or cancer?	YES	NO
Are you frequently ill?……...…….	YES	NO
Are you considered a nervous person?	YES	NO
Has a doctor ever said your blood pressure was too high...……...……YES		NO
Have you been told you have osteoporosis?	YES	NO
Have you been told you have rheumatoid arthritis?…….……...	YES	NO

Health Survey

In our chiropractic office we provide many services for your health. To get an idea of what you want and expect please take the following survey.

How would you rate your current health? Poor Fair Average Good Excellent

Do you want to live a long & healthy life? Yes No

If you answered yes above, how much time **per day** outside our office are you willing to commit to this goal?

_____hours _____minutes

Please score yourself from 1 to 10 below in each health category and then indicate if you are interested in receiving help in these areas. You can select as many or as few as you like.

Musculoskeletal pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain) I would like help and/or info on decreasing my pain: Yes No

Diet and nutrition: 1 2 3 4 5 6 7 8 9 10 (1 horrible diet, 10 excellent diet) I would like help and/or info on improving my diet and nutrition: Yes No

Exercise program: 1 2 3 4 5 6 7 8 9 10 (1 horrible exercise habits, 10 excellent exercise habits) I would like help and/or info on exercise: Yes No

Ability to sleep well: 1 2 3 4 5 6 7 8 9 10 (1 horrible sleeper, 10 excellent sleeper)
I would like help and/or info on getting a good nights sleep: Yes No

Stress level: 1 2 3 4 5 6 7 8 9 10 (1 no stress at all, 10 extreme stress) I would like help and/or info on decreasing my stress: Yes No

Headache frequency: 1 2 3 4 5 6 7 8 9 10 (1 constant headaches, 10 never)
I would like help and/or info on decreasing my headaches: Yes No

Pharmaceutical drug intake: 1 2 3 4 5 6 7 8 9 10 (1 daily intake, 10 never) I would like help and/or info on alternative solutions: Yes No

Energy Level: 1 2 3 4 5 6 7 8 9 10 (1 no energy at all, 10 endless energy) I would like help and/or info on increasing my energy level: Yes No

Other areas of health that you may need help:

_____

_____

_____

I AGREE that Concierge Mobile Chiropractic and Dr. Neda Nafei and her staff can email me at the email address on file, or call, WhatsApp or text message me at the phone number on file, even if I am on a federal or state Do Not Call Registry for any purpose, including marketing. Message and data rates may apply. I agree that the calls and text messages may be generated using an automatic telephone dialing system and may contain pre-recorded or artificial voice messages. I understand that consenting to receive calls or texts is not required to receive this service.

Sign:_____ Date:_____