WELCOME TO
PURE LIFE CHIROPRACTIC NEUROLOGY

Confidential Patient Information

Name		Date
Address		City/ State/ Zip Code
Home Phone	Work Phone	Cell Phone
Email Address	Date of Birth	Provider AT&T Sprint T-Moblie Verizion
SSN:	Current Age	

Work Status: Employed Retired Disabled Full-time Parent/Spouse Student

Employer	Occupation	
Employer Address	City State	Zip Code

Marital Status: please circle Married Single Divorced Widow

Spouse's Name/Cell Phone _____

Previous Chiropractic Care? Yes No Doctor's Name:_____

Name of Your Insurance Company _____

Who (or what source) referred you? _____

The below may not directly pertain to why you are seeing Dr. Borbón but please do not leave blank.

What is your #1 Short Term Goal (6 months or less)?

Ex: Eliminate pain, Learn a new hobby/skill, Weight loss, Get regular quality sleep

What is your #1 Long Term Goal (6 months - 3 years)?

Ex: Write a book, Run a Marathon, Advance your career, Lead a charity, More free time with family/friends, Graduate

Please list your major complaints in order of severity (form most debilitating to least debilitating):

Please circle the single greatest complaint below

1 _____ 2 _____ 3 _____

When did you first notice this condition? _____

Did it begin: Immediately or Gradually?

What is the exact location of your symptoms?_____

Do your symptoms spread? No Yes Where? _____

How often do you experience these symptoms?
●Constant (100% of day) ●Frequent (75%) ●Often (50%) ●Seldom (25%) ●Rarely (less than 25%)

Is this condition progressively: Worsening Improving Unchanged

What is the intensity of you symptoms? Severe Moderate Mild

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain)

1 2 3 4 5 6 7 8 9 10

Please indicate the character of your pain: __ Dull __Sharp __Burning __Aching __Knife-like __Throbbing
Other: _____
Are you experiencing any of the following associated symptoms?
__Pins/Needles __Tingling __Numbness __Twitching
If yes, please describe:

_____

WORSE: Please indicate what activities aggravate your condition:

_____

BETTER: Please indicate what helps alleviate the pain.

_____

Please list any doctors and/or treatments you used for this condition. (Please include diagnoses, treatment received, supplements/medications and any changes in your condition):

Please include any other relevant history you feel Dr. Borbón should know.

Personal Health History

Medications Please list your current medications, what they are taken for, and how long you've been taking them.
Vitamins and Minerals Please list your current supplements and by whom prescribed.

Place a check for any condition you had in the PAST, and the right box for any condition that is CURRENT

P C		P C		P C		P C	
__ __	Mental Disorders	__ __	Diabetes	__ __	Pneumonia	__ __	Infective Disease
__ __	Epilepsy	__ __	Anemia	__ __	Tuberculosis	__ __	Fungal Infection
__ __	Tumors	__ __	Glaucoma	__ __	Hepatitis	__ __	Herpes
__ __	Alcoholism	__ __	Heart Disease	__ __	Thyroid Disease	__ __	Arthritis
__ __	Drug Addiction	__ __	Rheumatic Fever	__ __	Parasites	__ __	Autoimmune Diseas
__ __	Cancer	__ __	Scarlet Disease	__ __	Asthma	__ __	Chicken Pox

NERVOUS SYSTEM		EYES/EARS/NOSE/THROAT		GASTROINTESTINAL		MUSCULOSKELTAL	
P C		P C					
__ __	Depression	__ __	Vision Problems	__ __	Poor/Excess Appetite	__ __	Neck Pain
__ __	Memory Loss	__ __	Flashing Lights	__ __	Excessive Thirst	__ __	Upper Back Pain
__ __	Confusion	__ __	Black Spots	__ __	Frequent Nausea	__ __	Lower Back Pain
__ __	Dizziness	__ __	Blurriness	__ __	Hemorrhoids	__ __	Hip/Knee Pain
__ __	Fainting	__ __	Hearing Loss	__ __	Black/Bloody Stools	__ __	Ankle/Foot Pain
__ __	Convulsions	__ __	Ringing in Ears	__ __	Digestive Problems	__ __	Shoulder/Elbow Pain
__ __	Weakness	__ __	Swallowing Difficulty	__ __	Abdominal Cramping	__ __	Wrist/Hand Pain
__ __	Poor Balance	__ __		__ __	Gas/Bloating	__ __	Between Shoulders
__ __	Twitches/Tremor	__ __		__ __	Heartburn/GERD	__ __	Rib Pain
__ __	Cold/Tingle Extremitie	__ __		__ __	Weight Problems	__ __	Sore Muscles
__ __	Sleeping Difficulties	__ __		__ __	Gall Bladder Problem	__ __	Difficulty Walking
__ __	Headaches	__ __	Increased Clumsiness	__ __	Liver Problems	__ __	Leg/Arm Pain

CARDIOVASCULAR		REPRODUCTIVE		GENITOURINARY	
__ __	Chest Pain	__ __	Erectile Difficulties	__ __	Bladder Trouble
__ __	Irregular Heartbeat	__ __	Sexual Dysfunction	__ __	Painful Urination
__ __	High Blood Pressure	__ __	Menstrual Irregularity	__ __	Incontinence
__ __	Shortness of Breath	__ __	Menstrual Cramping	__ __	Discolored Urine
__ __	Lung/Congestion	__ __	Venereal Infection		
__ __	Varicose Veins				
__ __	Ankle Swelling				

Females only: When did your menses first begin?

How often do you have a bowel movement?

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Do your stools __Float or __ Sink

Are your bowel movements consistent? __Yes __ No

How many times a day do you urinate?

Do you experience any urgency, dribbling, or incontinence?

Is this urination pattern consistent? __ Yes __ No

Past Medical History

Please include any of you previous conditions
If possible, include: dates, diagnosis, treatment received and any residuals you still suffer from.

General Health History: Have YOU had any of the following?

Injuries, Accidents, Falls, or Traumas (Including Sport Injuries) __No __Yes Explain
Illnesses/Hospitalizations __No __Yes Explain
Surgeries: __No __Yes Explain

Motor Vehicle Accidents __No __Yes Explain

Females Only: Menopausal Symptoms: __None __Yes Explain:

Habits

Cigarettes/Cigars	__None __Yes	How much per week?	
Alcohol	__None __Yes	How many drinks per week?	What types of alcohol?
Coffee	__None __Yes	How many cups per week?	
Exercise	__None __Yes	Hours/Days per week?	Types?
Water	__None _ Yes	Glasses per day?	
Soft Drinks	__None __Yes	Amount per week?	Types:

Sleep	__None __Yes Average per night? Do You have difficulty **falling asleep** or **staying asleep**? Hours desired per night?
Eating	Meals per day? _____ Do you consider your diet healthy? __Yes __No Explain

Have any of your FAMILY MEMBERS ever suffered from any of the following conditions?
Please specify the relation to persons below.

__Diabetes __Heart Disease __Stroke __Neurological Disorders __Mental Disorders
__Autoimmune Disorders_____ __Cancer _____
__Other _____

Authorization And Consent To Chiropractic Adjustments, Special Procedures And/Or Therapy And Consent to Payment/Cancellation/Reschedule Policy

Printed Name: _____

Pure Life Chiropractic Neurology maintains personnel and facilities to assist your doctor in the performance of chiropractic adjustments, special diagnostic, and other therapeutic procedures. These adjustments and ancillary procedures all may involve a calculated risk of complication, injury, or even death, from both known and unknown causes and no warranty of guaranty has been made as to the result or cure. Except in emergency or exceptional circumstances, these therapies and procedures are therefore not performed on patients unless and until a patient has had an opportunity to discuss them with his/her doctor. Each patient has the right to consent or refuse any proposed procedure or therapy based upon the prescription or explanation received.

The doctor(s) has determined that until the procedure(s) listed below may be beneficial in the diagnosis or treatment of your condition. Upon your authorization of your consent, such therapies or special procedures will be performed by your doctor.

Your signature opposite the procedure(s) listed below constitutes your acknowledgement(s) that:

(1) Your have read and agreed to the foregoing; (2) The procedure(s) and possible alternate means of therapy have been adequately explained to you by your doctor; (3) You consent to the office policy and procedure(s) or specified tests; (4) You consent to procedures and tests in addition to or different from those specified below, whether or not arising from presently unforeseen conditions, which your doctor might consider necessary or advisable in the course of the procedure(s) specified below; (5) No guaranty of a cure has been promised to you.

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that you cancel your scheduled appointment by phone or e-mail a minimum of 24 hours in advance. The payment/cancellation/reschedule details listed here define our Office Policy. The Office Policy supports the greatest ability to serve those desiring an appointment.

For consultations and exams of new patients with a friend/family or professional referral discount, failure to provide such notice will result in forfeiture of the savings offered.

For appointments, if you do not cancel by the deadline, you will be assessed a $48.00 missed appointment fee. This fee is will be your responsibility to pay at the time of your next visit or will be deducted from any prepayment on file. Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated.

Patient treatment plans are meticulously formulated on a patient by patient basis. Recommended frequencies and time frames of implementation of the treatment plan will be covered with the patient prior to its commencement. No action will take place without the full agreement of the patient. Therefore, failure of the patient to fulfill his/her duties of the treatment plan is the responsibility of the patient. This includes, but is not limited to, not showing up for the treatments. In such a case where thirty days has elapsed since the previous patient visit, during the correctional treatment phase, no refund will be made available. The patient's initiation of the treatment plan is the agreement that he/she will complete it.

I, (Printed Name)_____, understand and give my consent to the information above as well as to the physical exam, chiropractic adjustment, ancillary therapy(ies), and office policy.

Signature:_____ Date:_____

If Minor:
Guardian's Name:_____ Relation:_____ Date:_____