Masula Chiropractic
Neurology and Family Wellness

A Functional Neurology Group
30 Philadelphia Drive Suite A
Chico, CA 95973
Work: (530)342-6441
Fax: (530)342-5441

Demographics (PLEASE PRINT) Today's Date: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F

Cell Phone: _____ Email Address: _____

Work Phone: _____ Social Security: _____

Circle ALL that apply: Married Single Widowed Divorced Employed Retired Homemaker Student

Referred to this office by: _____

Employment Information

Employer: _____ Job Title: _____

Address: _____ City: _____ State: _____

Name of Spouse: _____ Spouse's Occupation: _____

Spouse's Employer: _____

Insurance _____

Emergency Contact Information

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Relationship: _____

Is this visit related to worker's compensation?	Y	N
Is this visit related to any legal actions?	Y	N
Is this visit related to any sort of motor vehicle accident?	Y	N

Patient Condition

Please Describe the Major Problem That Brings You In Today To See A Chiropractic Neurologist:

_____

_____

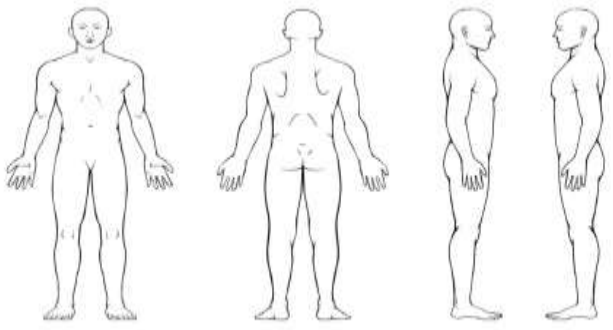
_____

When did this condition begin**:** _____ Have you ever experienced a similar problem in the past? Y □ N

How long has it been since your last medical/chiropractic evaluation? _____

If you follow a specific diet please describe: _____

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10= the worst pain imaginable?

Please circle:

1	2	3	4	5
6	7	8	9	10

How are your symptoms changing?
Please circle:

Getting better Not changing Getting worse

Please circle if you have the pain or difficulty performing the following:

Bending	Carrying Groceries	Change position (sit-stand)	Climbing stairs	Yard work
Driving	Extended computer use	Household chores	Sexual activities	Walking
Feeding	Reading (concentration)	Self-care (dressing)	Pet care	Sleeping
Lifting	Lifting children	Self-care (bathing)	Static Sitting	Kneeling

Other: _____

Family History: Do you have a family member affected with:

Brain Tumor	Seizures or Epilepsy	Dementia	Parkinson's	Multiple Sclerosis	Thyroid Disease
Muscle Disease	Neuropathy	Other Neurological Disorder		Hypertension	Diabetes
Migraines	High Blood Pressure	Stroke	Alcoholism	Depression	Heart Disease

Any Other Conditions_____

Review of Symptoms Do you currently, or have you had a problem with (please circle):

Constitutional:
Fever
Weight loss >5 lbs.
Excessive fatigue
History of falls

Gastrointestinal:
Nausea
Vomiting
Blood in your vomit
Liver disease
Jaundice
Abdominal pain
Change in bowel habits
Ulcers, Reflux

Endocrine:
Diabetes
Thyroid disease
Excessive thirst/Urination

Psychiatric:
Anxiety
Depression

Eyes:
Wear glasses/contacts
Infections
Injuries
Glaucoma
Cataracts

Ear, Nose, Throat & Mouth:
Wear hearing aid(s)
Hearing loss
Ear pain/Infections
Ringing in ears
Balance (vertigo etc.)
Nasal congestion/Drainage
Nose bleeds
Inability to smell
Sinus problems

Genitourinary
Urinary tract infections
Painful urination
Blood in your urine
Difficulty w/ urine stream
Incontinence
Kidney stones

Integumentary:
Unusual moles
Skin Disease
Breast tenderness
Nnipple discharge

Cardiovascular:
Chest pain or angina
High blood pressure
Regular pulse
Heart Murmur
High cholesterol
Swelling in hands or feet
Leg pain while walking

Musculoskeletal:
Broken bones
Arm or leg numbness
Arm or leg tingling
Arm or leg pain
Hand or feet weakness
Hand or feet numbness
Hand or feet tingling
Hand or feet pain
Joint pain or swelling
Arthritis
Neck pain
Mid-back pain
Low back pain

Respiratory:
Asthma
Emphysema
Shortness of breath
Pneumonia
Bloody sputum

Female:
Are you pregnant? Y N
Have you ever used HRT?

Neurological:
Fainting spells
Seizures
Disorientation
Difficulty with speech
Inability to concentrate
Double or blurred vision
Headaches
Problems with memory
Weakness in arms and/or legs
Loss of sensation
Difficulty with balance

Hematologic/Lymphatic:
Anemia
Hemophilia
Blood transfusion
Persistent glands/lymph nodes
HIV

Allergic/Immunologic:
Food, Inhalant (nasal) allergies
Autoimmune disease (i.e., lupus)

Surgical History Please list all operations you have had:

_____

_____

_____

Medical History Please list all active medical conditions:

_____

_____

_____

Please list all medications and supplements you take routinely, prescribed or over-the-counter, along with the dosages:

_____

_____

Social History

Hobbies: _____

Do you smoke cigarettes? Y N Do you drink alcohol? Y N Do you use recreational drugs? Y N

Do you exercise regularly? Y N

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort **(Relief Care).** Others are interested in having the cause of the problem as well as the symptoms corrected and relieved **(Corrective Care).** Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ **Relief Care Relief** care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that is getting wet from a leak, but not fixing the leak

□ **Corrective Care** differs from relief care in that the goal is to get rid of the symptoms or pain while correcting the cause of the problem. care varies in length of time, but is more lasting

□ Check here if you want the Doctor to select the type of care appropriate for your condition.

Financial Agreement

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Dr. Masula's Office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. The patient also agrees that he/she is responsible for all bills incurred at this office.

My signature below indicates that I have read, understand and agree to all of the above listed information.

_____

Responsible Party/Guardian Signature