Dr. Steven M. Pittson D.C.
Doctor of Chiropractic

Initial Health Status

Patterson Chiropractic Center Inc. 420 W. Las Palmas Ave, Patterson, California 95363 (209) 892-2915 (Fax) (209) 892-2938

Name: ______ Birthdate: ______ Sex : ☐ M ☐ F S.S#______
Address: ______ City: ______ State: ______ Zip: ______
Telephone: ( ) - ______ Cell Phone: ( ) - ______ Referred by:______ Email: ______

Occupation: ______ Employer: ______ Work Phone: ( ) -
Address: ______ City: ______ State: ______ Zip: ______
Subscriber Name: ______ Health Plan: ______ Subscriber ID #: ______
Group #: ______ Spouse Name: ______
Spouse Employer: ______ City: ______ State: ______ Zip: ______
Primary Care Physician Name: ______ PCP Phone: ( ) -

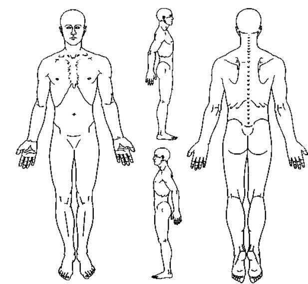
MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

Describe Your Current Problem and How it Began:

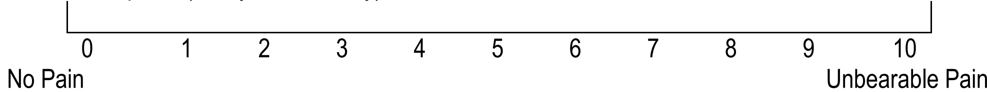
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low-Back Pain
☐ Other: ______

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: / / ______
How Problem Began: ______
What makes it worse:



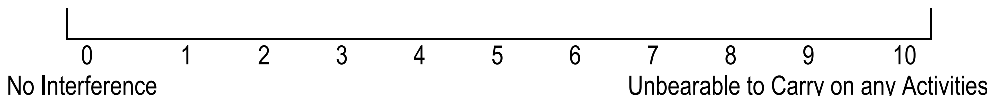
Current complaint (how you feel today):



0 1 2 3 4 5 6 7 8 9 10
No Pain — Unbearable Pain

How often are your symptoms present? (Intermittent) ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?



0 1 2 3 4 5 6 7 8 9 10
No Interference — Unbearable to Carry on any Activities

Quality: sharp dull or achy(explain pain)

Have you had Spinal X-Rays, MRI, CT Scan for your area(s) of Complaint? ☐ Yes ☐ No

Date(s) Taken: ______ What area(s) were taken: ______

☐ Recent Fever/ fatigue/ night sweats/ nausea
☐ Diabetes
☐ High Blood Pressure
☐ Stroke Date: ______
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control
☐ Dizziness / Fainting/ tingling
☐ Cancer / Tumor (explain): ______
☐ Surgeries: ______
☐ Other Health Problems (explain): ______
☐ Medications ______

☐ Numbness in Groin / Buttocks
☐ Osteoporosis
☐ Epilepsy / Seizures
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # of weeks: ______

☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain / Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Smoker ☐ Non-smoker
☐ Allergies
☐ Weight: Height:
☐ asthma/ shortness of breath/ wheezing

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems / Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature: ______ **Date:** ______