

**CHIROPRACTIC
FAMILY
HEALTH CENTER**

99-115 Aiea Heights Dr., Ste. 260, Aiea, HI 96701 Phone: (808) 486-6696 Fax: (808) 486-6695

(Please Print Clearly)

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Social Security #: _____
Birth Date: _____ Age: _____ Sex: M / F Marital Status: S M W D
Employer: _____ Occupation: _____
Work Address: _____ Work Phone: _____
Spouse's Name: _____ Spouse's Birth Date: _____ Spouse's SS# _____
Names & Ages of Children: _____

How did you hear about this clinic? _____
Have you ever been to a chiropractor before? Y / N If so, when? _____

Check off any of the following symptoms you have experienced in the past 6 months:

- | | | | |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bladder/Kidney Trouble | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Allergies | |
| <input type="checkbox"/> Numbness/Tingling in Arms or Hands | <input type="checkbox"/> Numbness/Tingling in Legs or Feet | <input type="checkbox"/> Fatigues | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other _____ | | |

Which of the above is worst? _____
How long have you had it? _____

Medications:

Lifestyles:

serving of fruits/day _____
serving of vegetables/day _____
exercise _____ x/week
hour of sleep _____ hr/day

Social Habits:

Alcohol (drinks/week) _____
Soda (cans/day) _____
Smoker (#/day) _____
Coffee (cups/week) _____

Insurance Information (If Applicable)

Work comp _____ Auto _____ Personal Health Insurance _____ Other _____
Insurance Co.: _____ Name of Insured: _____
Claim or Policy #: _____ Subscriber: _____

Please notify the doctor if you are or possibly pregnant

1. All first visit charges are payable when services are rendered.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes they cannot be released without proper written request.
3. Method of payment for today's services: Cash _____ Check _____ MC/Visa _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Dr. Paul Kurihara's office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Dr. Paul Kurihara 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 my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount. I authorize Paul W.Y.Kurihara, D.C., LMT to obtain a credit report, if necessary.

Patient's Signature: _____ Date: _____

PATIENT HEALTH HISTORY

The vast majority of our patients have been involved in dozens of **IMPACTS** that could cause **VERTEBRAL SUBLUXATION**, or *Spinal Misalignments*. Please list as many as you can recall whether major or minor and whether you were injured or not.

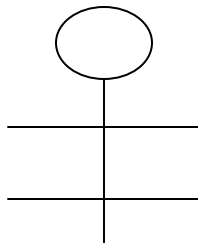
Please list Traumas (i.e. accidents, work injuries, recreational/sports injuries, childhood traumas, illnesses, surgeries, etc.) below.

Date:	Trauma:	Were you checked for SUBLUXATION?
• _____	_____	Y N
• _____	_____	Y N
• _____	_____	Y N
• _____	_____	Y N
• _____	_____	Y N
<ul style="list-style-type: none"> • What sports or recreational activities do you currently do, or have done in the past? _____ • On a scale 0-10, what is your stress level at <u>home</u>? (0-relax, 10-extremely stress) _____ • On a scale 0-10, what is your stress level at <u>work</u>? (0-relax, 10-extremely stress) _____ 		

Bilateral Weight Scales

R _____ L _____

Posture



Other Comments
