INFIFNITE BODY HEALTH
Minet Sepulveda, DC

General Information

Name: ____ Date of Birth (M/D/Y): ___/___/___ Age: __________

Address: ____ Sex: ◯ Male ◯ Female

City: _______________, CA. Zip Code: ___________ Email: ____

Home Phone: _______________________________ Cell Phone: _____________________________________

Employer: _________________________________ Work Telephone: ______________________Ext.________

Occupation: __________________________________ ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Name of Spouse: _______________________________Spouse's Employer: _______________________________

Spouse Occupation: ______________________ Number of children and ages: ___________________________

How were you referred to this office? ____

Emergency Contact: ____________________ Phone: _________________ Relationship: __________________

Medical Insurance

1. Do you have medical insurance? ◯ Yes ◯ No *(If yes, please provide us with a copy for your file)*
2. Are you the principal insured? ◯ Yes ◯ No

   If no, name of the principal insured: ___________________________Date of birth (M/D/Y): ___/___/___
3. Have you consulted another healthcare professional with this problem? ◯ No ◯ Chiropractor

   ◯ Physician ◯ Physical Therapy ◯ Other:________________________________
4. List any other doctors you have consulted for this condition:

   *1)*____ *2)*____
5. Chiropractic care received in the past: ◯ Yes ◯ No When: ______________________________
6. If Yes, please rate your experience: (Negative) 1 2 3 4 5 6 7 8 9 10 (Positive)

   Chiropractor's Name: ____

Chief Complaint

7. What's the reason for your visit today? Please list all your health problems, starting with the most important.

   1) ______________________ *2)* _________________________ *3)*___________________________

   *4)*_______________________ *5)*__________________________*6)*___________________________

8. How long have you have the main problem listed above? _________________________________

9. How did it start?: ◯ Gradually ◯ Suddenly ◯ Because of an accident ◯ I'm not sure

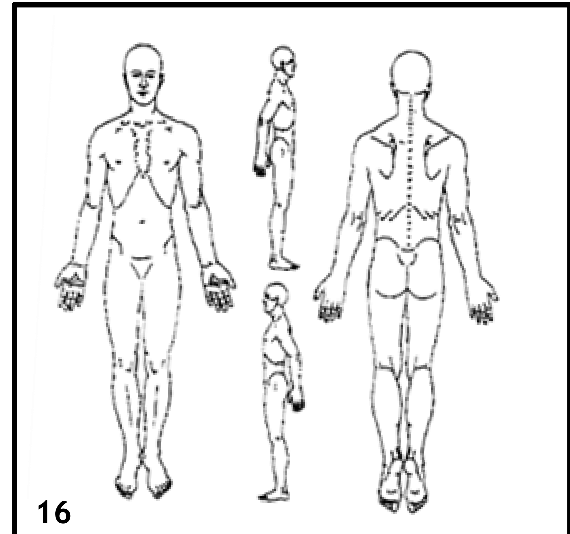
10. It is present: ◯ 100% of the time ◯ 75% of the time ◯ 50% of the time ◯ 25% of the time ◯ Less than 25% of the time

11. Your condition is: ◯ improving ◯ worsening ◯ remaining the same

12. Your problem is worse during: ◯ Morning ◯ Mid-day ◯ Afternoon ◯ Night

13. This affects: ◯ Your job ◯ How much you sleep ◯ Recreation ◯ Time spent with family ◯ Your daily routine

14. Have you had this problem before? ◯ Yes ◯ No



15. Indicate the severity.

    (No problem) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Problem)

16. Indicate all parts of the body where you have problems. Please check ALL areas, even if they are small and are not the reason for your visit.

Consent for healthcare of a minor: I, being the parent or legal guardian of the minor, give permission for evaluation, X-rays, and chiropractic care.

Signature: ____**Date:** ___________________

INFIFNITE BODY HEALTH
Minet Sepulveda, DC

Medical History / Symptoms

Patient Name: ________________________________ **Date:** _________________ **HRN**___________

17. Father's age: ______________ If deceased, what was the cause? ______________________________

18. Mother's age: _____________ If deceased, what was the cause? ______________________________

19. Do you have siblings? ◯ Yes ◯ No

20. In your family, is there history of: ◯ Heart trouble ◯ Diabetes ◯ Artritis ◯ Cancer ◯ Other:_________________________

21. Are you taking any medications? ◯ Yes ◯ No

    If yes, which ones are you taking?
    - ◯ Hormones
    - ◯ Anti-Inflammatory
    - ◯ For blood pressure
    - ◯ Pain killers
    - ◯ For diabetes
    - ◯ Muscle relaxants
    - ◯ For thyroid glands
    - ◯ Over-the-counter drugs
    - ◯ Contraceptives

22. In which position do you work? ◯ Standing-up ◯ Sitting-down ◯ Moving

23. Normally, do you sleep: ◯ On your back ◯ On your side ◯ On your abdomen

24. On average, how many hours do you sleep at night?

    ◯ 4hrs or less ◯ 5-6 hrs ◯ 7-8 hrs ◯ 8-10 hrs ◯ 10-11 hrs ◯ 12 hrs or more

Please mark each item with a "P" for Past, "A" for Actively, or "N" for Never

☐	Headaches	☐	Jaw pain, TMJ	☐	Hormonal imbalance
☐	Dizziness	☐	Neck pain	☐	Pregnancy (now)
☐	Fainting	☐	Shoulder pain	☐	Pre-menstrual syndrome
☐	Imbalance	☐	Chest pain	☐	Menstrual problems
☐	Double vision	☐	High back pain	☐	Menopause
☐	Blurred vision	☐	Middle back pain	☐	Prostate problems
☐	Ringing in ears	☐	Lower back pain	☐	Impotence
☐	Loss of hearing	☐	Back curvature	☐	Colon problems
☐	Seizures / Epilepsy	☐	Scoliosis	☐	Pancreas problems
☐	Convulsions	☐	Hip pain	☐	Liver problems
☐	Tremors	☐	Problems with hands	☐	Bladder problems
☐	Asthma	☐	Problems with knees	☐	Abnormal Gas
☐	Allergies	☐	Problems with feet	☐	Reflux
☐	Shortness of breath	☐	Arthritis	☐	Eating disorder
☐	Sinusitis	☐	Swollen joints	☐	Digestive problems
☐	Lung problems	☐	Numbness/tingling hands, fingers	☐	Ulcers
☐	Common cold	☐	Numbness/tingling feet, toes	☐	Kidney stones
☐	Pain when coughing	☐	Psychological problems	☐	Diarrhea / constipation
☐	Heart trouble	☐	Moodiness	☐	Trouble urinating
☐	High blood pressure	☐	Irritability	☐	Urination at night
☐	Low blood pressure	☐	Anxiety	☐	Frequent urination
☐	Circulation problem	☐	Depression	☐	Blood in urine
☐	Swelling	☐	ADD/ADHD	☐	Blood in excrement
☐	Bruising	☐	Fatigue	☐	Hepatitis (A, B, C)
☐	Rash	☐	Chills	☐	Meningitis
☐	Skin lesions	☐	Cold extremities	☐	Hypoglycemia
☐	Fractures	☐	Any type of disability	☐	Diabetes
☐	Hereditary conditions	☐	Trouble sleeping	☐	Thyroid
☐	Cancer	☐	Reproductive System Issues	☐	Adrenal
☐	Fibromialgia	☐	Chronic Fatigue Syndrome		

Daily Activities: Effects of Present Conditions in Your Performance

Identify how your condition is affecting your ability to perform daily activities:

Activity				
Sitting	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Rising from Sitting	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Standing	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Walking	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Running	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Pivoting / Twisting	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Pushing	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Bending	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Climbing	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Lifting objects	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Carrying objects	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Concentrating	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Reading	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Watching television	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Working at computer	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Working	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Managing / Leading	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Gardening	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Recreational activities	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Sports	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Dancing	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Dressing	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Housework	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Sexual activity	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this
Sleeping	☐ Has no affect	☐ Causes slight pain	☐ Causes moderate pain	☐ I cannot do this

Initial Profile of the Nervous System

25. When was your most recent car accident? ____
26. What was the driving speed? ____
27. Type of impact: ◯ Front Impact ◯ Side Impact ◯ Rear Impact (whiplash)
28. Were you treated? ◯ Yes ◯ No Please describe: ___________________________________
29. Does your work require you be in a position that aggravates your condition? ◯ Yes ◯ No
    Please describe:____
    (e.g., sitting all day, lifting objects constantly, computer use)
30. Have you had any trauma to the spine in the past? ◯ Yes ◯ No
    Please describe any sports injuries:____
    (e.g., football, boxing, basketball, ball, soccer, tennis, golf, track and field)
    Please describe any childhood traumas:____
    (e.g., falls, head impacts, bicycle accidents)
    Please describe any day-to-day issues: ____
    (e.g., working at home, lifting, bending, waking up with back or neck pain)

Initial Profile of Nutrition

31. Have you had triglycerides or high cholesterol? ◯ Yes ◯ No Values: ___________________
32. Have you had high blood pressure? ◯ Yes ◯ No
33. Are you diabetic of have you been diagnosed with pre-diabetes to a metabolic syndrome?
    ◯ Yes ◯ No
34. Do you eat breakfast every day, from Monday to Sunday? ◯ Yes ◯ No
35. How many days a week do you skip at least one meal? ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more
36. How much fast food do you eat a week? ◯ 0 ◯ 1 - 3 ◯ 4 - 6 ◯ 7 or more
37. How much refined foods (flour, pasta, tortilla) do you eat a week?
    ◯ 0 ◯ 1 - 3 ◯ 4 - 6 ◯ 7 or more
38. How many pre-made meals do you eat a week? ◯ 0 ◯ 1 - 3 ◯ 4 - 6 ◯ 7 or more
39. How many servings of fruit do you consume daily? ◯ 0 - 1 ◯ 2 - 3 ◯ 4 or more
40. How many servings of vegetables do you consume daily? ◯ 0 - 1 ◯ 2 - 3 ◯ 4 or more
41. How many servings of protein do you consume daily? ◯ 0 - 1 ◯ 2 - 3 ◯ 4 or more

42. Do you consume: Alcohol ◯ Yes ◯ No How many times per week?__________________

Tobacco / Cigars ◯ Yes ◯ No How many times per week?__________________

Coffee / Tea ◯ Yes ◯ No How many times per week?__________________

Vitamins ◯ Yes ◯ No How many times per week?__________________

Diet Soda ◯ Yes ◯ No How many times per week?__________________

Regular Soda ◯ Yes ◯ No How many times per week?__________________

Juice ◯ Yes ◯ No How many times per week?__________________

Cow's Milk ◯ Yes ◯ No How many times per week?__________________

Energy Drinks ◯ Yes ◯ No How many times per week?__________________

Sleeping Pills/Tranquilizers ◯ Yes ◯ No How many times per week?__________________

Artificial Sweeteners ◯ Yes ◯ No How many times per week?__________________

43. List any supplements you take daily: ____

____

Initial Profile of Exercises

44. How many times a week do you exercise?

Cardiovascular: ______ hours ______ days/week

Lifting weights: ______hours ______days/week

Low impact (Yoga, stretching, etc.): ______hours _______days/week

45. What is your ideal weight? _____________ What is your current weight? ___________

Initial Profile of Toxicity

46. Are you exposed daily to detergents and / or industrial chemicals? ◯ Yes ◯ No

47. Have you noticed any type of fungus or mold present in your home or workplace? ◯ Yes ◯ No

48. Does your home, car, or workplace smell musty? ◯ Yes ◯ No

49. Have you received your immunizations? ◯ Yes ◯ No

50. Are you vaccinated annually for colds or flu? ◯ Yes ◯ No

51. How many of these shots have you received? ___________

52. Has any member of your family been diagnosed with multiple sclerosis? ◯ Yes ◯ No

53. Has any member of your family been diagnosed with chemical sensitivity? ◯ Yes ◯ No

54. Has any member of your family been diagnosed with fibromyalgia, chronic fatigue syndrome or depression? ◯ Yes ◯ No

Initial Profile of Stress

55. Do you feel you do not have enough time to do tasks and procrastinate? ◯ Yes ◯ No
56. Do you experience anxiety about completing your tasks? ◯ Yes ◯ No
57. Do you ignore or feel you do not pay enough attention to important areas of your life such as family, personal enrichment, and / or leisure? ◯ Yes ◯ No
58. Do you use an agenda when making your plans or do you use your memory to keep track of things?
    ◯ Agenda ◯ Memory
59. Do you take time to pray and /or meditate regularly? ◯ Yes ◯ No
60. How many times per week do you experience extreme tension (family or financial) or stress at work? ________________

61. Please describe. ____

62. Do you see a therapist for stress? ◯ Yes ◯ No Please describe _________________________
    ____

Healthcare Goals

63. People consider chiropractors for a variety of different reasons. Some people go for pain relief, others to correct the cause of pain or for prevention. Your doctor will weigh your needs and desires when recommending your wellness program. Please mark the desired type of goals, so we could focus on your wishes, whenever it's possible.

    ◯ Symptomatic relief - Relief of pain or discomfort

    ◯ Corrective Care - Correct, relieving, stabilizing the cause of your problem.

    ◯ Prevention - Keeping your body to the highest degree of health.

    ◯ I want the doctor to select the appropriate type of care for my condition.

64. Indicate the level of your commitment to fix the problem.
    (Not very committed) 1 2 3 4 5 6 7 8 9 10 (Totally committed)
65. How committed are you to taking the measures to improve your general health?
    (Not very committed) 1 2 3 4 5 6 7 8 9 10 (Totally committed)