Kings Canyon Chiropractic

4842 E. Kings Canyon Road, Ste. 103, Fresno CA 93727
Phone: 559-255-7121 Fax: 559-255-7120

Welcome to our office!

Please take some time and fill out ALL the enclosed paper work.
In order to be seen by the Doctor, all paper work needs to be filled out before your appointment.

Sincerely,

Angie
KCC Staff

Name: _____ SS#: _____Age: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Work/Cell Phone: _____ Birth Date: _____

Height:____ Weight:____ Sex:____Employed by:_____ Spouse's Name:_____

Email: _____Spouse's Birth Date: _____

Referred By**: (Friend) (Relative) (Sign) (Telemundo) (Univision) (Azteca) (Clasificado) (Sol)**

(Internet) (T.V.) (Yellow Page) (Orale) (Radio) (Pique) (La Especial) (Other: _____)

Please circle your current symptoms:

(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper-Back Pain) (Knee Pain)

(Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain) (Hand Pain)

(Chest Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other: _____)

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

List all surgeries in the past five years: _____

Have you ever had spinal surgery? (No) (Yes: _____)

List any serious condition the doctor should be aware of: _____

Previous Chiropractor: _____ Were you satisfied? (No) (Yes)

***Females: Are you pregnant at this time**? (No) (Yes) **Due Date: _____**

Office Policies: *If I am accepted as a patient at the Kings Canyon Chiropractic Office I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care.*

Consent To Treat: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Dao/Dr. Mai to proceed with any necessary treatment. I have read Dr. Dao/Dr. Mai's office policies and consent to treat information, and I agree with them by signing below:*

Signature:_____Date:_____

Parent/Guardian's Signature: _____Date:_____

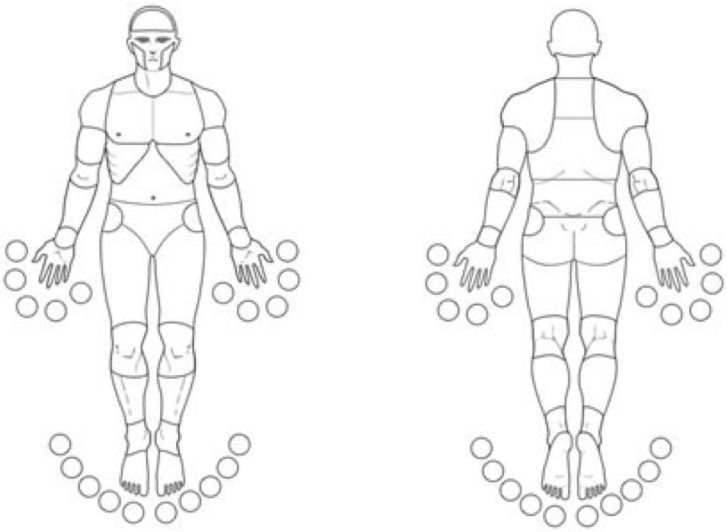
Kings Canyon Chiropractic ~ 4842 E. Kings Canyon Road #103 ~ Fresno, CA 93727 ~ Phone: 559-255-7121 ~ Fax: 559-255-7120

Patient History Form

Patient Name: _____Date: _____File #:_____

On the diagrams to the right, please mark where you are experiencing any symptoms:

Use the following as a guide:
P= Pain
T= Tingling
N = Numbness
B = Burning
W = Weakness



The following questions pertain to your **PRIMARY problem**:

Is the pain constant? YES NO N/A **Is the numbness/tingling constant?** YES NO N/A

How long have you been suffering with your condition? _____

Have you had any problems like this in the past?_____

Has it been getting worse? YES NO **If yes, how long has it been getting worse?** _____

How would you describe the pain? Achy, Sharp, Burning, Numbness, Needle, Pressure, Tightness_____

How would you rate your pain on a scale of 1 (best) to 10 (worst)?

Currently: 1 2 3 4 5 6 7 8 9 10 **On Average:** 1 2 3 4 5 6 7 8 9 10

At Its Best: 1 2 3 4 5 6 7 8 9 10 **At Its Worst:** 1 2 3 4 5 6 7 8 9 10

Did your problem come on gradually or suddenly? Gradual Sudden Not sure

Was there any type of injury that may have caused your problem?

_____

_____

What aggravates your problem? Bending Lifting Twisting Turning Sitting Standing Walking Sitting-to-Standing Laying Down Reading Computer Driving Getting in/out of vehicle
Other: _____

Do any of these RELIEVE the pain? Heat, Ice Stretching, OTC Pain Meds, Rest, Nothing
Other:_____

Is your problem worse in the: Morning, Afternoon, Evening, At Night, During Sleep,
All the Same

Have you been told exactly what condition you have?

_____

Have you tried any of the following?: Results of treatment: (circle one for each)

Muscle Relaxers (Prescription): YES NO No Relief Worse Temporary Relief

Anti-Inflammatory Meds (Prescription): YES NO No Relief Worse Temporary Relief

Pain Medications (Prescription): YES NO No Relief Worse Temporary Relief

Physical Therapy: YES NO No Relief Worse Temporary Relief

Chiropractic: YES NO No Relief Worse Temporary Relief

Massage Therapy: YES NO No Relief Worse Temporary Relief

Acupuncture: YES NO No Relief Worse Temporary Relief

Injections (including epidurals): YES NO No Relief Worse Temporary Relief

Spinal Surgery: YES NO No Relief Worse Temporary Relief

Have you been told you need an injection? YES NO By whom? _____

Have you been told you need spinal surgery? YES NO By whom? _____

Have you ever had:

A spine fracture? YES NO
Bone cancer? YES NO
Bone infection, disease, or disorder? YES NO
Abdominal aneurism? YES NO
Night cramping? YES NO ---> Hands Fingers Calves Feet Toes Right Left
Swelling? YES NO ----> Hands Fingers Legs Ankles Feet Right Left

Do you have any muscle weakness in the arms or legs yet? YES NO Arms Legs Right/Left

Do you have any muscle atrophy (loss of muscle tone) yet?YES NO Arms Legs Right/Left

How is this affecting your life?

_____

_____

How serious do you consider this?

_____

What do you think will happen if left untreated?

_____

_____

Kings Canyon Chiropractic

Dr. Lien Dao, DC & Dr. Loc Mai, DC * Email: kccfresno@gmail.com
Phone: (559) 255-7121* Fax: (559) 255-7120
4842 E. Kings Canyon Rd., Suite 103
Fresno, CA 93727

Patient's Name: _____Date: _____

[Please **circle the number** which most closely describes your chief complaint(s) today:**]**

1. Pain Intensity

(0)	(1)	(2)	(3)	(4)
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Frequency Of Pain

(0)	(1)	(2)	(3)	(4)
No Pain	Occasional Pain	Intermittent Pain	Frequent Pain	Constant pain
25% of the Day	50% of the Day	75% of the Day	100% of the Day	

3. Personal Care (Washing, Dressing, Etc.)

(0)	(1)	(2)	(3)	(4)
No Pain	Mild pain	Moderate Pain	Moderate Pain	Severe Pain
No Restrictions	No Restrictions	Need to go slowly	Need some assistance	Need 100% Assistance

4. Travel (Driving, Riding, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain	Mild Pain	Moderate Pain	Moderate Pain	Severe Pain
On Long trips	On Long Trips	On Long Trips	On Short Trips	On Short Trips

5. Work

(0)	(1)	(2)	(3)	(4)
Can Do Usual Work Plus Extra Work	Can Do Usual Work No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

(0)	(1)	(2)	(3)	(4)
Can Do all Activities	Can Do Most Activities	Can Do 50% Activities	Can Do 25% Actitives	Cannot work

7. Sleeping

(0)	(1)	(2)	(3)	(4)
Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

8. Lifting

(0)	(1)	(2)	(3)	(4)
No pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight	Increased Pain

9. Walking

(0)	(1)	(2)	(3)	(4)
No Pain Any Distance	Increased Pain After One Mile	Increased Pain After Half Mile	Increased Pain After Quarter Mile	Increased Pain With All Walking

10. Standing

(0)	(1)	(2)	(3)	(4)
No Pain After Several Hours	Increased Pain After Several Hours	Increased pain After One Hour	Increased Pain After Half Hour	Increased Pain With Any Standing

Kings Canyon Chiropractic

Dr. Lien Dao, DC & Dr. Loc Mai, DC * Email: kccfresno@gmail.com
Phone: (559) 255-7121 * Fax: (559) 255-7120
4842 E. Kings Canyon Road, Suite 103, Fresno CA, 93727

Patient Health History Worksheet

Patient's Name:_____ Date:_____

Significant Past Health History

Have you ever been hospitalized?
a) No
b) Yes: (Year :_____) Reason: (_____)

Have you had any surgeries?
a) No
b) Yes: (Year :_____) (Reason :_____)
(Year :_____) (Reason :_____)
(Year :_____) (Reason :_____)
Do you have any significant health problems?
a) No
b) Yes: (_____)

Significant Past Medical History

Have you seen another doctor for this condition?
a) No
b) Yes: (_____)

Did this doctor recommend any treatment?
a) No
b) Yes: (_____)

Are you taking any medication?
a) No
b) Yes: (_____)

Significant Past Social History

Do you play any sports or exercise?
a) No
b) Yes: (_____)

How many hours do you sleep a night? (_____)

How many hours a week do you work? (_____)

Significant Family Medical History

Did your father have any health problems?
a) No
b) Yes: (_____)

b) Yes: (_____)

Did your grandpa have any health problems?
a) No
b) Yes: (_____)

Did your grandma have any health problems?
a) No
b) Yes: (_____)

Health Risk Factors

Do you drink alcohol?
a) No
b) Yes: (_____)

Do you smoke?
a) No
b) Yes: (_____)

Anything else the doctor should know about?
a) No
b) Yes: (_____)

Did your mother have any health problems?
a) No
b) Yes: (_____)

Did your brother(s) have any health problems?
a) No
b) Yes: (_____)

Did your sister(s) have any health problems?
a) No