Paniz Chiro Care, LLC **Phone: (714) 204-1296**

Name:	DOB	AGE	DOI/DO onset of Complaint	Today Date
Address:			City	Phone Number:

PATIENT DEMOGHRAPHIC INFORMATION

Patient ID Number: _____

First Name: _____ Last Name: _____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____ P h o n e # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Home Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone: _____ ☐ W ☐ H ☐ C

Are you Medicare Eligible? ☐ Yes ☐ No

Height: ft. in. Weight lbs.

Occupation: For how long? yrs. mos.

Have you had chiropractic care before?: ☐ Yes ☐ No If yes, How recently?

If you were referred by someone please tell us who so we may thank them. Referral: _____

1st Phone _____ ☐ W ☐ H ☐ C 2nd Phone _____ ☐ W ☐ H ☐ C

Email _____

What is your preferred method of communication? ☐ Phone ☐ Text ☐ Email

I AGREE that Paniz Chiro Care, LLC, its affiliates, vendors, and agents can email me at the email address above, or call or text message me at the 1st phone number above, even if I am on a federal or state do not call registry for any purpose, including marketing. Message and data rates may apply. I agree that the calls and text messages may be generated using an automatic telephone dialing system and may contain pre-recorded or artificial voice messages. I understand that consenting to receive calls or texts is not required to receive this service.

_____ _____

(Patient or Legal Guardian Signature) Date

Please choose from the options below:

☐ Self-Pay Consult:
- Wellness Care
- Neck and/or Back problem

☐ Insurance Carrer:
- Wellness Care/ Maintenance
- Neck/ Back/ .... Problem

☐ Accident & Injury:
- Auto Accident
- Slip & Fall

3RD PARTY INFORMATION:

INSURANCE CARRIE:_____

ADJUSTOR NAME:_____

CLAIM NUMBER:_____

INSURANCE COMPANY PHONE NUMBER:_____

FAX NUMBER:_____

ADJUSTER PHONE NUMBER: _____

Law Firm/ Attorney Name:_____

Paniz Chiro Care, LLC

Phone: (714) 204-1296

Name: DOB AGE DOI/DO onset of Complaint Today Date

Address: City Phone Number:

PATIENT ACTIVITY ASSESSMENT

Name: Today's Date:

Occupation: _____ Age: _____

The purpose of this form is to assist the doctor in better understanding your daily activities, your ability to perform them, and how they relate to the function of your body. Your answers will provide important information in establishing a customized plan of care designed to place you on the path toward attaining and maintaining your health care goals.

STANDING OR SITTING

Do you primarily stand or sit at work? ☐ Stand ☒ Sit

Approximately how many hours per week?
☐ 0-20 hours ☐ 20-40 hours ☐ 40+ hours

Are those hours primarily spent:
On the phone: ☐ Yes ☐ No
Typing at a keyboard: ☐ Yes ☐ No

What is your most common posture?
☐ Sitting upright ☒ Slouched ☐ Crossed legs ☐ Stand

Does your work require you to?
☐ Bend ☐ Twist ☐ Lift ☐ Carry ☒ N/A

What type of shoes do you wear on a regular basis?
☐ Dress ☐ Heels ☐ Running ☐ Boots ☐ Athletic ☒ Sandals
☐ Other _____

Do you wear orthotics: ☐ Yes ☒ No

SLEEPING

What type of bed do you sleep on?
☐ Memory foam ☐ Adjustable firmness ☒ Inner spring
☐ Other _____

How many hours of sleep do you get per night? ☐ 8 hrs or less ☒ More than 8 hrs

What position do you sleep in? ☒ Back ☐ Stomach ☐ Side ☐ All

Do you regularly wake up with any back stiffness: ☒ Yes ☐ No

Do you regularly wake up with any neck stiffness: ☒ Yes ☐ No

BODY STRESSORS

Do your daily activities require you to lift and/or carry objects: ☐ Yes ☒ No

If yes, how often: ☐ Occasionally ☐ Frequently ☐ Constant

If yes, approximately, how heavy: ☐ 10 lbs. or less ☐ 10-30 lbs. ☐ Over 30 lbs.

Do you exercise: ☒ Yes ☐ No

If yes, approximately how many days per week: ☐ 0-1 day(s) ☒ 1-3 days ☐ 3+ days

Type(s) of exercise:
Weight training: ☐ Freeweights ☐ Machines ☐ Other: _____
Cardio training: ☐ CrossFit ☐ Yoga ☐ Running ☒ Other: walking

Do you participate in sports: ☐ Yes ☒ No

If yes, please indicate all that apply: ☐ Skiing ☐ Bodybuilding ☐ Soccer ☐ Tennis ☐ Walking/Hiking ☐ Volleyball ☐ Racquetball ☐ Yoga ☐ Dancing ☐ Cycling/biking ☐ Golf ☐ Football ☐ Basketball ☐ Other _____

Do you have children at home? ☐ Yes ☒ No
If yes, how many? ☐ 1 ☐ 2-3 ☐ More than 3

Do any of your children require you to carry them? ☐ Yes ☐ No

CHIROPRACTIC ACTIVITY ASSESSMENT

Did You Know: the absence of pain is not an indication of health? ☐ Yes ☐ No

Did You Know: pain has a cause and many times that cause begins in the spine? ☐ Yes ☐ No

Did You Know: over-the-counter pain medications and/or prescriptions may only mask the pain? ☐ Yes ☐ No

Did You Know: your daily activities can cause joint pain and dysfunctions in the spine and extremities? ☐ Yes ☐ No

Did You Know: these joint dysfunctions can cause decreased joint motion and function in the body? ☐ Yes ☐ No

Did You Know: decreased joint motion can also affect your ability to enjoy a healthy and active lifestyle? ☐ Yes ☐ No

Did You Know: the healt benefits of routine chiropractic care may include any of the follwing? ☐ Yes ☐ No

1) Improved nervecommunication
2) Improved joint motion
3) Improved joint coordination
4) Improved physical function
5) Improved physicalperformance
6) Improved posture
7) Increased daily activity
8) Provide pain and stress relief

Our mission is simple: "To improve quality of life through routine and affordable chiropractic care. We congratulate you on your decision to invest in your- self and commitment towards achieving improved joint function and healthier, more active lifestyle. Our journey towards that goal begins here.

(Patient or Legal Guardian Signature)

(Date)

Paniz Chiro Care, LLC Phone: (714) 204-1296

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Paniz Chiro Care, LLC

General Informed Consent

I understand that chiropractic care and wellness treatment may involve manual therapy, Physical modalities, exercise therapy, and diagnostic evaluations.

I consent to treatment and understand risks, benefits, and alternatives.

Patient Signature: _____ Date: _____

HIPAA Acknowledgment

I acknowledge receipt of the Notice of Privacy Practices. I consent to use and disclosure of my health information for treatment, payment, and healthcare operations.

Signature: _____ Date: _____

Assignment of Benefits / Signature on File

I authorize payment of medical benefits from my Health Plan with …….directly to Paniz Chiro Care Clinic/ Dr. Asef A. Maleki. I understand I am financially responsible for non-covered services.

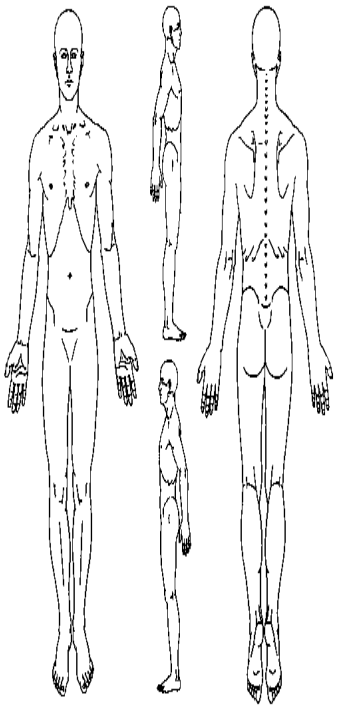
Signature: _____ Date: _____

Paniz Chiro Care **9368 Valley View Dr. NW Albuquerque NM. 87114** **P: 714-204-1296**

PATIENT NAME:		DOI/DO of complaint:		DATE:	

Fill out the sections below for each area of pain you are experiencing.
* circle for right or left
*Area of complaint/ pain examples include: Headache, Neck, Upper back, Lower back, Shoulder, Knee, Hip, Elbow, Arm, Wrist, Leg, Ankle, Foot, etc.
* please rate your pain intensity in each section? Area of complaint/pain.

Please mark area and type of pain on the drawings using the codes listed below.
A = Ache
B = Burning
D = Dull
S = Stabbing
N = Numbness
P = Pins and Needles
T = Tingling
Th = Throbbing



***Area of pain*:..... R L Bilateral**

Frequency: Occasional Intermittent Frequent Constant
Description: Achy Dull
Burning HOT
Throbbing Sharp
Stabbing Pins &Needles
Other:……..
Duration: All day Most of day Variable
usually…….minutes/…….hours

When did your pain/ complaint/ condition begin?
_____
Today, is the condition: Same ☐ Better ☐ Worse
Did you have any event/ accident/ injury related to begin this complaint? If so When did your injury/accident occur? _____
What makes your condition better?
_____
What makes your condition worse?
_____
Does your pain travel down your arms or legs?
_____
Is there any: Numbness Tingling Weakness
_____
PAIN SCALE
Please circle the number that best describes your pain
0 1 2 3 4 5 6 7 8 9 10
None Little Medium Severe
_____

***Area of pain*:..... R L Bilateral**

Frequency: Occasional Intermittent Frequent Constant
Description: Achy Dull
Burning HOT
Throbbing Sharp
Stabbing Pins &Needles
Other:……..
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PAIN SCALE
Please circle the number that best describes your pain
0 1 2 3 4 5 6 7 8 9 10
None Little Medium Severe
_____

Reason for today's visit: ☐Pain ☐Discomfort ☐Stiffness ☐Maintenance Care ☐Recent Injury ☐ Previous Injury ☐ Other

you experienced this/these complaint(s) before?
☐Yes ☐ No If yes, when?

What, if any, Medication, Nutritional Supplements, And/or ointments Are you taking for Pain?.....

***Area of pain*:.....R L Bilateral**

Frequency: Occasional Intermittent Frequent Constant
Description: Achy Dull
Burning HOT
Throbbing Sharp
Stabbing Pins& Needles
Other:……..
Duration: All day Most of day Variable
usually…….minutes/…….hours

When did your pain/ complaint/ condition first begin?
_____
Today, is the condition: Same ☐ Better ☐ Worse
Did you have any event/ accident/ injury related to begin this complaint? If so When did your injury/accident occur? _____
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0 1 2 3 4 5 6 7 8 9 10
None Little Medium Severe

Patient Signature:

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PATIENT NAME:		**DOI/DO of complaint:**		**DATE:**	

Are your symptoms as a result of an injury? **YES** / **NO** If **YES,** please circle which kind: **Auto Accident, Work Injury, Slip & Fall, Sports**

FAMILY HISTORY (Please Check)					
	DIABETES	HEART	KIDNEY	CANCER	OTHER
MOTHER					
FATHER					
BROTHER					
SISTER					
OTHER					

EXERCISE (Please Circle)
None
Light Activity
Moderate Activity
Active
Very Active
Elite Athlete

SOCIAL HISTORY (Please Circle)	
Smoking: Packs/Day-	Yes/ No
Alcohol: Glasses /Day/Week-	
Caffeine: Cups/Day-	
Cell Phone/Pad/Computer Usage Hours/Day:	
Energy Drinks	

PAST HISTORY: PLEASE CIRCLE IF YOU HAVE HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS

Headaches/Migraines	**Fused/Fixated Joints**	Stroke	Cancer
Neck Pain/Discomfort	**Herniated Disc**	Heart disease	**Tumors**
Shoulder Pain/Discomfort	**Joint Replacement**	**Pacemaker**	**Hernia**
Upper Back Pain/Discomfort	Swollen Joints	Rapid Heart	**Weight Loss/ Gain**
Middle Back Pain/Discomfort	Painful Joints	Slow Heart	**Bleeding Gums**
Low Back Pain/Discomfort	**Stiff Joints**	**High Blood Pressure**	Ear noises
Hip Pain/Discomfort	Sprain/Strains	**Diabetes Type 1 or 2**	Deafness
Hip replacement		**High Cholesterol**	Sinusitis
sciatica			Pain Behind Eyes
Elbow Pain/Discomfort	**Fibromyalgia**	Mental disorder	Enlarged Thyroid
Wrist Pain/Discomfort	**Multiple Sclerosis**	**Epilepsy/Seizure Disorders**	Nose Bleeds
Knee Pain/Discomfort	**Weak Muscles**		
Knee Replacement		Goiter	HIV Positive
Ankle Pain/Discomfort		Lupus	Tuberculosis
Arthritis	Depression	Pleurisy	**Hepatitis (B / C)**
Rheumatic Fever	Anxiety	Asthma	Pneumonia
Arthrosis		Appendicitis	**Kidney Infection**
Osteoporosis	**Allergies**	Anemia	Ebola
Osteopenia	Eczema	Kidney Dysfunction	Venereal Disease
	Dermatitis	**Prostate Problems**	Polio
		Loss Of Bladder Control	Measles
		Liver Trouble	Chicken Pox
		Constipation	Whooping Cough
		Alcoholism	Mumps
		Opioid Addiction	Influenza

List all surgeries you have had:

List any broken bones or dislocations you have had?

PATIENT NAME:		DOI/DO of complaint:		DATE:	

Circle any accidents or falls you have had and write the dates of when they occurred:

Auto	Work	Sports	Recreation	Other

Circle if you have had any of these procedures:

Spinal Tap	Spinal Injections (ESI)	Neck Surgery	Mid Back Surgery	Low Back Surgery

Are you currently experiencing any of the following (If yes to any, please describe below)

- ☐ Nausea or vomiting
- ☐ Rapid eye movement
- ☐ Numbness on one side of the face or body
- ☐ Fainting or lightheadedness
- ☐ Dizziness
- ☐ Difficulty Walking
- ☐ Headache or neck pain
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Loss of sleep
- ☐ Poor Appetite
- ☐ Black Stool and/or Bloody Stool
- ☐ Difficulty Speaking
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Loos of Bladder Control
- ☐ Rash
- ☐ Swollen Joints
- ☐ N/A

FOR MEN ONLY

Prostate Problem
Painful Erection
Testicular
Difficulty Having Sex

FOR WOMEN ONLY

Birth Control
Hormone Replacement
Pain Cramps/ Backaches
Excessive Flow
Hot Flashes
Irregular Cycle
Miscarriage
Painful Periods
Vaginal Discharge
Breast Pain
Difficulty Having Sex

Are you Pregnant or
Do you Suspect you are Pregnant?

Yes NO

List all Medications you are Currently Taking:

1.	2.	3.
4.	5.	6.
7.	8.	9.

EMERGENCYCONTACT- **RELATIONSHIP-** **CONTACT NUMBER-**

Patient Signature:_____