SHAPERO CHIROPRACTIC
CHIROPRACTOR TO THE UNIVERSITY OF SAN FRANCISCO
ATHLETIC DEPARTMENT

300 MONTGOMERY STREET – SUITE 204
SAN FRANCISCO, CA 94104
P. (415) 397-2544
F. (415) 434-1533

Who may I thank for referring you to my office?_____

Information about You

First Name_____ Last Name_____

Home # _____ Cell # _____ Work# _____

Address _____ City _____ State _____ Zip _____

Email _____ Age _____ Birth Date _____

□ widowed □ single □divorced/separated □married/partnered to (name)_____

Favorite hobbies or interest _____

Emergency contact _____ Phone _____

Name of Employer _____ Location/City _____

Information about Your Financial Responsibilities

Who is responsible for payment? _____ SS# _____

Insurance Co. _____ Group policy # _____

Insured's Name _____ Subscriber ID # _____

Signature _____ Date _____

Information about You and Chiropractic

What brought you here today? (Please check one OR both)

□ The concern of a symptom or condition.

□ The desire to improve your health and well-being.

Have you ever been to a chiropractor before? □ yes □ no

If yes, who were the chiropractor(s)? _____

Why did you seek chiropractic care? _____

For how long did you receive chiropractic care? □ 1-3 visits □ 4-8 visits □ <3months □ 6months □ >1yr

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? □ yes □ no

If yes, please describe _____

What do you want to receive from your chiropractic experience here? _____

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Information about your Current Health

What are your most pressing health concerns? _____

_____

For how long and when did it start? _____

In your WHOLE life have you ever had a health concern in this area(s) of your body? □ yes □ no

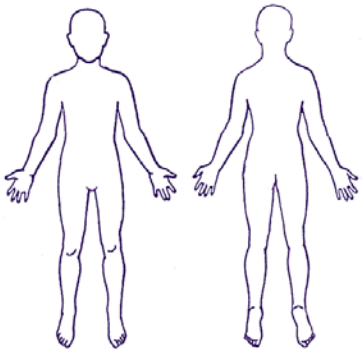
If yes, when was the first time? _____

Have you consulted any other doctor/practitioner for this health concern? □ yes □ no

If yes, please list the date, name, and credentials _____

Are your health concerns… □ improving □ getting worse □ staying the same

What are the concerns? Please use the illustrations and lines below to explain.



Front _____

_____

_____

Back _____

_____

_____

On a scale of 1-10 (1=least, 10=most), please rate (by circling) the severity of your current symptoms

1 2 3 4 5 6 7 8 9 10

Do you have… □ pain □ numbness □ tingling □ throbbing

Is your pain… □ burning □ dull □ sharp □ shooting □ aching □ throbbing

When do you feel your pain… □ constantly □ frequently □ intermittently □ occasionally

Are your concerns affected by… □ standing □ sitting □ bending □ walking □ lying down □ weather

Do your concerns interfere with… □ work □ day-to-day activities □ sleep □ play

□ energy levels □ relationships □ financial □ other

Do you mostly use your LEFT Hand/Foot or RIGHT Hand/Foot? [Please circle]

Are you currently taking any prescription medication or pain relievers for this particular concern? □ yes □ no

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Information about Your Health History

Birth and Childhood

Did you have any birth trauma? □ yes □ no □ don't know □ not sure

Do you recall any major or minor injuries as a child? □ yes □ no □ don't know □ not sure

Did you have any of the following: □ mumps □ influenza □ rheumatic fever □ smallpox □ polio □ chicken pox □ epilepsy □ whooping cough □eczema □ measles

Past injuries DO affect present health (check all boxes that apply within the course of your life)

□ moving accidents or collisions (ever)	□ sport injuries	□ spinal tap	□ wear dental appliances
	□ broken bones	□ surgeries	□ traction
□ falls/accidents	□ dislocations	□ fractures	□ use(d) cane
□ head injuries	□ spinal injuries		□ extensive dental work

If yes to any of the above, please describe _____

REVIEW OF SYSTEMS-WHOLE BODY

The questions below are important to build an overall picture of your physical well being to give an actual assessment for your adjustment-care. Patterns with your past and current conditions will reflect a clearer picture of your actual health.
CHECK any box that represents your past/current body area NOT FUNCTIONING 100%

□ **Head Area**	□ **Midback Area**	□ **Liver**	□ hormonal irregularities
□ dizziness	□ breasts/lumps	□ jaundice	□ menses irregularities (PMS, heavy, painful)
□ confusion	□ **Lungs**	□ anemia	□ constipation
□ headaches/migraines	□ breathing difficulties	□ **Gallbladder**	□ hemorrhoids
□ fatigue/drained	□ shortness of breath	□ Pancreas	□ black or bloody stools
□ vision	□ pneumonia	□ diabetes	□ **Skin Conditions** (acne, pimples, rashes)
□ hearing	□ irritable bowel	□ **Kidney**	□ **Immune System**
□ sinus	□ colitis	□ **Bladder**	□ allergies
□ jaw area L/R	□ pleurisy	□ excessive urination	□ frequent colds, flu, sore throat, coughing
□ **Neck Area**	□ **Stomach**	□ discolored urine	□ frequent infections
□ tonsillitis	□ indigestion	□ painful urination	□ cancer
□ thyroid dysfunction	□ gas/bloating	□ **Low Back/Pelvis**	□ arthritis
□ laryngitis	□ heartburn, acid	□ leg pain/tingling	□ sexual function
	□ coughing	□ poor/excess appetite	□ knee pains
□ **Shoulder Area L/R**	□ **Heart**	□ cold feet	□ circulation
□ arm/hand tingling	□ heart disease/stroke	□ ankle swelling	
□ tennis elbow L/R	□ irregular heart beat	□ shin splints	
□ cold hands	□ abnormal blood	□ prostate pressure	

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Family History

Please list any family health history that may concern you and their relationship to you.

_____

Chemical Stressors **(work-related, nicotine, fragrances, perfume, foods, personal care products, home/car cleaning products, over-the-counter drugs)**

Would you say your conscious CHEMICAL Health is □ excellent □ okay □ poor □ don't know

Do you have any concerns in your life from past or present from chemical toxicities? □ yes □ no □ don't know

Have you ever taken any kind of antibiotics in the last year? □ yes □ no

If yes, please write down dates and the reason for medication _____

Do you smoke? □ no □ Yes/ If yes, how long? _____ OR Did you use to smoke? □ Yes If yes, how long?___

Women Only: Do you take birth control pills? □ yes □ no If yes, how long?_____

Do you take hormone replacement therapy (HRT)? □ yes □ no

Emotional Stressors **(If applicable)**

Would you say your Mental/Emotional Health is… □ excellent □ okay □ poor □ getting better □ getting worse

Do you ever feel like you have… □ depression □ weight loss/gain □ nervousness □ loss of sleep

Do you consider your job excessively stressful? □ yes □ no

Information about Your Lifestyle **PLEASE CHECK if you have had in the past or currently use any of the following:**

□ Massage/Bodywork □ Osteopathy □ Cranial Work □ Physical/Occupational Therapy □ Naturopathy □ Homeopathy
□ Herbalist □ Aromatherapy □ Acupuncture □ Reiki □ Psychotherapy/Counseling □ Nutritional Counseling
□ Allergies □ Hair Analysis □ Martial Arts □ Tai Chi □ Dance □ Yoga □ Pilate's □ Other

How many hours per week do you generally work? _____

How would you describe your sleep pattern? □ excellent □ well □ restless □ not very well

Do you sleep on your… □ stomach □ back □ side

Do you wake up… □ full of energy □ feeling rested □ feeling tired □ feeling exhausted

How is your energy overall… □ full power □ okay □ low □ off/on

How HEALTHY do you feel/think your immune system is… □ strong □ okay □ low □ don't know

How would you rate your eating habits? □ excellent □ pretty good □ could be better □ needs improvement

Do you drink alcohol? ____ coffee _____ tea _____ How much water do you drink each day? ____ glasses.

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The rating scale below is designed to measure the degree to which several aspects of your life are presently affected by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how frequently your health condition (pain and/or symptoms you may be experiencing) is present. Respond to each category by indicating the overall presence in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. A score of 0 means no presence at all and a score of 10 means that all of the activities in which you would normally be involved have been affected or prevented by your health condition (pain and/or symptoms you may be experiencing).

0	1	2	3	4	5	6	7	8	9	10
No presence at all/ No Discomfort									Present/ Uncomfortable	

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house. (Yard work, doing dishes, errands, favors for family, driving your children, etc.) _____

2. RECREATION: hobbies, sports, running, and other similar leisure time activities. _____

3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out and other social functions _____

4. OCCUPATION: activities that are part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker _____

5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping and breathing _____