Dr Tom Hibbard, DC

Limitless Health Chiropractic
100 E. Thousand Oaks Blvd. #147
Thousand Oaks, Ca 91360
(805)409-7071

Patient Intake Information

Date: ________________

Legal Name:____________________________________ Preferred Name: ______________________ Sex: M F

Address: ____ City:_________________ State: _____ Zip: ___________

Date of Birth: ____/____/_______ Age_____ SS #: ______-______-________

Home Phone: (____)_____-________ Mobile Phone:(____)______-_________ E-mail:___________________________

What is your preferred method of communication? ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email ☐Other

Employer:_________________________ Occupation:___________________Work Phone:(____)_______-__________

Emergency Contact:_______________________________________ Emerg. Contact Phone:(____)_______-__________

How did you hear about us? ☐ Internet ☐ Referral* ☐Other (What was the source?):_____________________________

*Who should we thank for the referral?_________________________________

Have you ever been treated by a chiropractor? ☐ YES ☐ NO **Date of Last Visit?**:_________________________

Which of Our Services Are You Here For? (Please check all that apply)

☐Consultation ☐Examination ☐Wellness Adjustment (No Symptoms) ☐Spinal Correction ☐Pain Relief ☐Decompression

Sports Related: ☐Improve Performance ☐Sports Taping ☐Myofacial Release ☐Physiotherapy/Rehab ☐Participation Physical

Stress Related: ☐ Massage ☐ Stress Analysis/Solutions ☐ Exercise Plan

Injury Relief: ☐ Sports Injury ☐ Work Injury (*Is this a workers compensation case?* ☐ YES ☐ NO ☐ Other Injury

Nutrition Related: ☐ Whole Food Supplements ☐ Dietary Recomendations ☐ Detox Programs ☐ Weight Loss Program

Other: ☐ Solve A Health Problem Other Doctors Couldn't ☐ I Would Like a Second Opinion.

☐ "I don't know. Please make recommendations after my exam." ☐ Other Reason For Visit:_________________________

____

Insurance and Payment Information

Who's responsible for this account?_________________________________Relationship Patient___________________

Will you be using Insurance? ☐YES ☐NO (If Yes, please fill in the information below):

Is patient covered by a secondary insurance? ☐YES ☐NO

Insurance Co._________________________Group#__________________Employer_____________________

Subscriber's Name____________________________ DOB___/___/______ SS# ______-______-________

Assignment & Release

I certify that I have insurance coverage and assign directly to Limitless Health Chiropractic all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of this signature on all insurance submissions.

__________________________________ ________________________ ________________
Responsible Party's Signature Relationship to Patient Date

Patient Name:____ Date:___________________________

Patient Condition

What is your presenting problem?____

When did this incident begin?__________________**If you had this in the past, how long ago?**__________________

What triggered/caused this problem? ____

Rate your level of pain (0=No Pain/10=Worst Pain Ever)**:** Currently is____out of 10. At its Worst is____out of 10.

Condition is: ☐ Getting Better ☐ Getting Worse ☐ Unchanging **Its Worse in:** ☐ Morning ☐ Afternoon ☐ Evening ☐ Other

Percentage of day you experience this:_____% **Quality of pain:** ☐ Burn ☐ Sharp ☐ Achy ☐ Cramp ☐ Knot ☐ Tingle

Does the pain travel? ☐YES ☐NO **Other Symptoms that may/may not be related:** __________________________

What makes your symptoms worse? ☐standing ☐sitting ☐walking ☐bending/lifting ☐lying down ☐other: _________

What makes your symptoms better? ☐heat ☐shower ☐ice ☐rest ☐pain medicine ☐other:____________________

Have you already recieved a diagnoses by another doctor for this concern? ☐ YES ☐ NO

If yes, what imaging was performed?: ☐ X-ray ☐ MRI ☐ CT Scan ☐ Ultra Sound ☐ DEXA ☐ Other

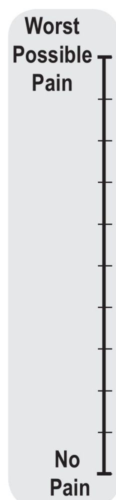
If yes, what treatment was performed?:____

Does your condition interfere with your daily activites? (work duties, daily life, social life, recreation, etc) ☐ YES ☐ NO

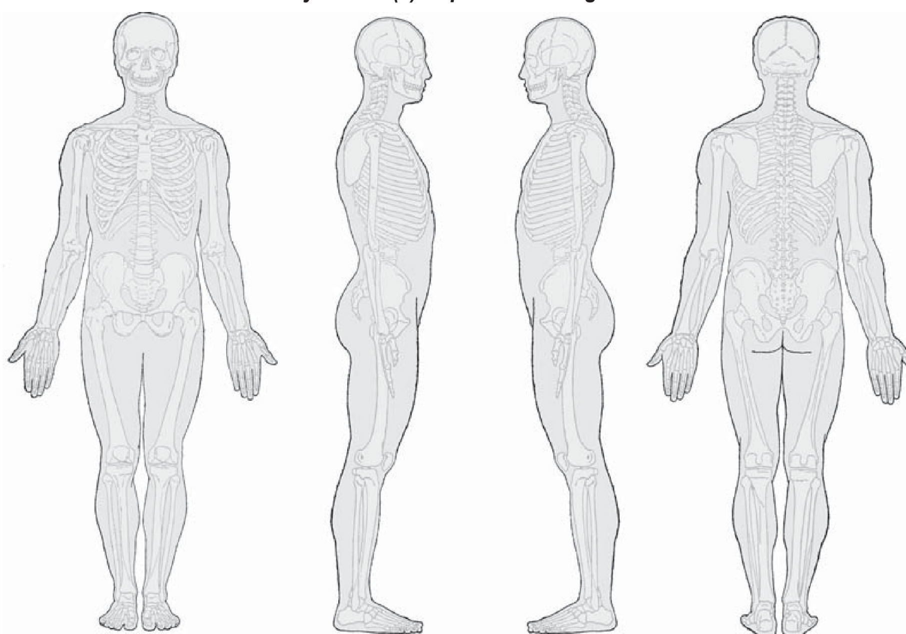
If yes, please describe specifically:____

Is there additional information that may be important? ____

Please place a mark at the level of your pain on the scale below:



Please mark you area(s) of pain on the figure below



Red Flags

Headache and Neck Pain patients, are you experiencing: (check all that apply)

☐ Blurred Vision ☐ Double Vision ☐ Trouble Swallowing or Speaking ☐ Dizziness

☐ Fainting Spells ☐ Nausea ☐ Trouble Walking/Loss of Balance ☐ Numbness in hands or feet

Low Back patients, are you experiencing: (check all that apply)

☐ Numbness in the Groin ☐ Bladder Disturbances ☐ Bowel Disturbances

Patient Name:____ Date:___________________________

Health History (Please check if you Have Had or Currently Have)

General: ☐Anemia ☐Cancer ☐Diabetes ☐High Cholesterol ☐Hypoglycemia ☐Epilepsy ☐RA ☐MS

☐Prostate Problem ☐Gout ☐Eczema ☐Hyper/HypoThyroid ☐Psoriasis ☐Anxiety ☐Depression ☐Chronic Fatigue ☐ Fibromyalgia

Gastrointestinal: ☐Gallbladder pain ☐Heart Burn ☐Bloating ☐Nausea ☐Blood in stool ☐Constipation ☐ Diarrhea

☐ Hiatal Hernia ☐ Irritable Bowel ☐ Chron's Disease ☐ Frequent belching ☐ Indigestion ☐ Ulcers ☐ Hemrorrhoids

Immune: ☐ Frequent Colds ☐ Frequent Flu ☐ Shingles Flare ups

Cardiovascular: ☐ Hypertension ☐ Angina ☐ Heart Attack ☐ Stroke

Nervous System: ☐ Dizziness ☐ Fainting ☐ Coordination loss ☐ Memory Loss ☐ Difficulty picking up coins from table

Ear, Eyes, Nose, and Throat: ☐ Eye problems ☐ Hearing loss ☐ Sore Throat ☐ Dental problems

Urinary Tract: ☐ Blood In Urine ☐ Incontinence ☐ Baldder infection ☐ Kidney stones

Muskuloskeletal: ☐ Sciatica ☐ Bulging Discs ☐ Scoliosis ☐ Osteoarthritis ☐ AS

Women: ☐ Pregnancy ☐ PMS ☐ Miscarriage ☐ Infertility ☐ Menopause

Any additional history of disease that may be important?____

____

Prior Type of Sugeries/Year of Surgery:____________________/Year:_______, ____________________/Year:_______,
____________________/Year:______, ____________________/Year:_______, ____________________/Year:_______

Please List Any Medications You are Currently Using, and for What Purpose:____________________________

____

Please List Any Supplements/Vitamins You are Currently Using:____

____

Family History (Does anyone in your family have any of the following?)

☐ Arthritis-Rheumatism ☐ Diabetes ☐ Osteoporosis/Osteopenia ☐ Autoimmune Disorder ☐ Heart Disease ☐ Stroke

☐ Back/Spine Condition ☐ Hypertension ☐ Thyroid Disorder ☐ Cancer ☐ Mental Illness ☐Other:__________________

Social History

My work duties include: ☐Standing ☐Sitting ☐Light Labor ☐Heavy Labor **Average hours worked per week:** _____hours

My exercise level is: ☐Intense ☐Moderate ☐Light ☐Minimal ☐None **My favorite exercise/activity:**___________________

Hours of sleep per night:____hours **How many times to you get up during the night (to urinate, etc)?**___times per night

Percent of diet from unprocessed foods:____% **Glasses of water per day?**____glasses **Source of water?**_________________

My Habits Include: Tobacco use _____ packs/day Alcohol consumption ____drinks/week Caffeine ____cups/day

☐ High Stress Levels ☐ Irregular Schedule ☐ Frequently worried/upset

What are your health goals for this year?____

____

What are your health goals for 20-30 years from now? ____

____

I certify that the above information is true, and I give permission for Limitless Health Chiropractic, and Dr Tom Hibbard, DC to use my above information for diagnosis and treatment recommendations. In addition, I consent to an examination, including orthopedic and neurological exams, as well as diagnostic imaging such as X-ray, as recommended by the above associates of Limitless Health Chiropractic. I understand the fee for x-ray is for analysis of the x-ray only, as the film itself is the property of the office. I understand that all services rendered to me are charged directly to me, and I am personally responsible for payment.

________________________________ ____________________ ______________
Patient/Guardians Signature Relationship to Patient Date