

Julia Lewis, D.C.

Wellness Solutions/Non-Force Chiropractic Center
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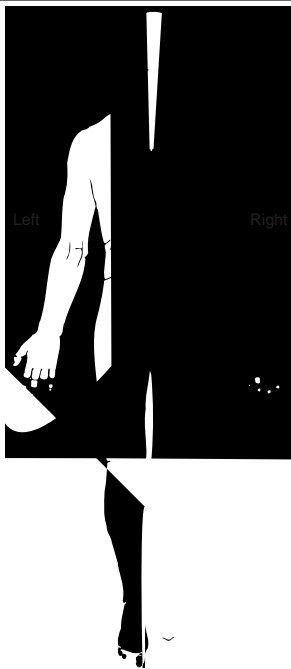
PATIENT INFORMATION SHEET

Date _____ Number (to confirm appointment) _____
 Name _____ Phone (Home) _____ Date Of Birth _____
 Address _____ Age _____ Sex: M F
 City _____ State _____ Zip _____ Marital Status S M D W
 Occupation _____ Employer _____ Telephone (Work) _____
 Spouse's Name _____ Spouse's Telephone (Work) _____
 Referred By _____ Past Chiropractic Care Yes No When _____
 Previous Chiropractor's Name _____ Results _____
 Areas where you hurt
 1. _____
 2. _____
 3. _____
 Social Security # _____ Driver's License # _____

Are your present complaints due to an injury? No Yes On the job Auto Accident Other _____
 Have you made a report of your accident? No Yes To employer Auto Carrier Other _____
 Are you now or have you ever been disabled? (Service or Work)? No Yes When _____
 Have you retained an attorney? No Yes Name & Telephone _____

To help us better explain your chiropractic condition and how we may be able to help you, please check the best answer:

- I remember important things in my life by
 - what I see.
 - what I hear.
 - what I feel.
- The primary reason I brush my teeth is to
 - avoid tooth decay and gum disease.
 - make sure I have healthy teeth and gums.
- When I make decisions I generally
 - gather facts and weigh the evidence.
 - make the right choice instantly.
 - consult my friends and family.
 - depend upon how I "feel" about it.

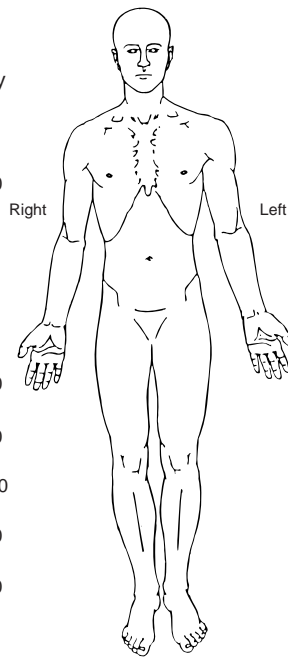


Severity of Pain
List region of pain and circle severity number. [1= least, 10 greatest]

example: Neck
1 2 3 (4) 5 6 7 8 9 10

Circle on Diagram
Where you hurt

1 _____
 1 2 3 4 5 6 7 8 9 10
 2 _____
 1 2 3 4 5 6 7 8 9 10
 3 _____
 1 2 3 4 5 6 7 8 9 10
 4 _____
 1 2 3 4 5 6 7 8 9 10
 5 _____
 1 2 3 4 5 6 7 8 9 10



HABITS		EXERCISE	FAMILY HISTORY				
<input type="checkbox"/> Smoking	Packs / day _____	<input type="checkbox"/> None	Diabetes	Heart	Kidney	Cancer	Back
<input type="checkbox"/> Drinking	Alcohol _____	<input type="checkbox"/> Moderate	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coffee	Cups / Day _____	<input type="checkbox"/> Daily	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Brother No. of ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Sister No. of ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OPERATIONS AND MEDICAL PROCEDURES

DATE _____ DATE _____

Please enter : "P" (Previously), "C" (Currently), In front of any of the following historically significant symptoms. Leave blank if never or only rarely experienced.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	RESPIRATORY	GENITO-URINARY
<input type="checkbox"/> Headache	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Fever	<input type="checkbox"/> Poor Digestion	<input type="checkbox"/> Spitting Blood	<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Chills	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Spitting Phlegm	<input type="checkbox"/> Blood In Urine
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Belching or Gas	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nausea	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Inability to control Urine
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Asthma	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Pain over Stomach		
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Constipation		
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Diarrhea		
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Colon Trouble		
<input type="checkbox"/> Numbness in (Circle) arms/legs/hands/feet	<input type="checkbox"/> Hemorrhoids		
<input type="checkbox"/> Pain in (Circle) arms/legs/hands/feet	<input type="checkbox"/> Liver Trouble		
	<input type="checkbox"/> Jaundice		
	<input type="checkbox"/> Gall Bladder Trouble		

MUSCLE & JOINTS	CARDIO VASCULAR	SKIN OR ALLERGIES	FOR WOMEN ONLY
<input type="checkbox"/> Weakness	<input type="checkbox"/> Rapid Heart	<input type="checkbox"/> Skin Eruptions	<input type="checkbox"/> Painful Periods
<input type="checkbox"/> Twitching	<input type="checkbox"/> Slow Heart	<input type="checkbox"/> Itching	<input type="checkbox"/> Excessive Flow
<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bruising Easily	<input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> Backache	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Dryness	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Pain over Heart	<input type="checkbox"/> Boils	<input type="checkbox"/> Cramps or Backaches
<input type="checkbox"/> Tremors	<input type="checkbox"/> Previous Heart Trouble	<input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Miscarriage
<input type="checkbox"/> Foot Trouble	<input type="checkbox"/> Swelling Ankles	<input type="checkbox"/> Hives	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Painful Tail Bone	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Eczema	<input type="checkbox"/> Pregnant at this Time
<input type="checkbox"/> Pain Between Shoulders	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Allergy	<input type="checkbox"/> Last Pap
<input type="checkbox"/> Hernia	<input type="checkbox"/> Strokes		By Who _____
<input type="checkbox"/> Spinal Curvature			Other _____

List any accidents or falls and dates: Car _____ Recreational Vehicle _____ Sports _____
 School _____ Other _____

List any broken bones or dislocations (Fractures): _____

Ever on crutches? No Yes Why? _____

Have you ever had any spinal taps or spinal injections? Yes No

Were you ever knocked unconscious?: Yes No Have you ever had a lapse of memory?: Yes No

Have you ever had x-rays taken?: No Yes _____ When? _____ By whom? _____

For what ailments were these pictures made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication - prescription or over the counter? No Yes

What Drugs? _____

I Understand that the payment for the care provided by Dr. Lewis is due at the time of service. I will be provided with a receipt for payment of services which I may send to my insurance company for appropriate reimbursement.

FEE SCHEDULE

Neurofeedback Evaluation\$150.00	Neurofeedback training.....\$60.00 / \$70.00
Initial Exam/Treatment.....\$150.00	Chiropractic/Specialty Treatment\$75.00

If for any reason an Appointment cannot be kept, notification must be made 24 hours in advance or you will be charged the full fee.

Patient Signature/Guardian Authorizing Care

Date

Are you covered by Medicare? _____