WELCOME TO HEALTH FOR LIFE

DR. DERRICK STANBRIDGE D.C.

6033 S. FASHION POINTE DR. #120 SOUTH OGDEN, UT 84403

801.475.6800 PHONE 801.475.6802 FAX

Thank you for choosing Health for Life for your Chiropractic and homeopathic injection needs. Please complete this form in ink. All information provided is confidential. If you have questions or concerns, please ask for assistance.

Name:_____DOB:_____Sex: M or F

Address:_____City:_____State:_____Zip:_____

Phone: (_____)_____Email:_____

Marital Status:_____Spouse's Name:_____Phone: (____)_____

Emergency Contact:_____Phone: (_____)_____

Nearest Relative Not Living with You_____Phone (_____)_____

Referral/How did you hear about us?_____

Responsible Party/ Insurance Information

Person responsible for account:_____DOB:_____

Relationship:_____ Phone: (____)_____

Address:_____City:_____State:_____Zip:_____

Primary Health Insurance Info

Carrier:_____Phone:(____)_____

Address:_____City:_____State:_____

Name of Insured:_____DOB: _____/_____/_____

Policy #:_____ Group#:_____

Patient Relationship to Insured: Self Spouse Child Other

Secondary Health Insurance Info

Carrier:_____Phone:(____)_____

Address:_____City:_____State:_____

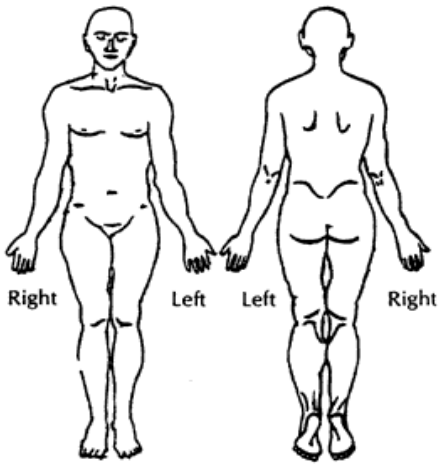
Name of Insured:_____DOB: _____/_____/_____

Policy #:_____ Group#:_____

Patient Relationship to Insured: Self Spouse Child Other

Patient completes this section:

Symptoms began on:_____
NOTES:



Indicate where you have pain

1. **Average Pain Intensity:**
   Last 24 hours (circle one) : no pain 1 2 3 4 5 6 7 8 9 10 worst pain
   Last week (circle one) : no pain 1 2 3 4 5 6 7 8 9 10 worst pain

2. **How often do you experience your symptoms?(circle one)**
   1 Constantly (76%-100% of time) **2 Frequently (51%-75% of time)**
   3 Occasionally (26%-50% of time) **4 Intermittently (0%-25% of time)**

3. **How much have your symptoms interfered with your usual daily activities?**
   (Circle one)
   Not at all A little bit Moderatley Quite a bit Extremely

4. **In general what would you say your overall health right now is?**
   (circle one)
   Excellent Very Good Good Fair Poor

Patient Signature:_____Date:_____

Chief Complaints or Symptoms **Name:**_____**Date:**_____

Neck Pain

(Check the areas that the pain runs into from neck)

□ none □ left shoulder □ left arm □ left forearm
□ left hand □ right shoulder □ right arm □ right hand
□ right forearm

□ Headache
□Migraine
□Upper Back Pain

Ringing in Ears? YES NO □ Left □ Right □ Both
Blurry Vision? YES NO □ Left □ Right □ Both
Wrist Pain? YES NO □ Left □ Right □ Both
Jaw Pain? YES NO □ Left □ Right □ Both

Low Back Pain

(Select the areas of radiation)

□ none □ buttocks □ left buttock □ right buttock
□ left thigh □ right thigh □left knee □ right knee
□left foot □ right foot

Hip Pain? □ Left □ Right □Bilateral
Knee Pain? □ Left □ Right □Bilateral
Foot Pain? □ Left □ Right □Bilateral

Additional Symptoms/Complaints

□ Numbness area:_____
□Dizziness
□Nervousness
□Fatigue
□Anxiety
□Depression
□Excessive Irritability
□Jaw clenching
□Grinding of teeth at night
□Nightmares
□Difficulty Sleeping

□Other:_____
_____

_____

Doctors Notes