

ZEN Chiropractic Center

Patient Data 基本资料:

Last Name 姓 First Name 名 Middle Name Soc. Sec. #

Birthdate 生日 / / (mm/dd/yy)

Tel 電話(H) (Cell) Occupation 职业

Address , City , State , Zip

Sex 性别 M 男 F 女 Married 已婚 Single 未婚 Other 其他

Employer Business Phone

Business Address E-mail:

Who referring you : YellowPg-HI Tel Internet/WebSite Klass HI ChiroPlan Website
 YellowPg-Paradise SuperPages.com 檀报 Other:

Spouse Information 配偶资料:

Last Name First Name Middle Name

Soc. Sec. DOB / / (mm/dd/yy)

Employer Address Occupation

Insurance Auto Accident Work Injury Health Medicare Other

Primary Insurance: Insurance Phone #

Insured's Name Male Female Insured's Phone

Relationship to Insured: Self Spouse Child Other Insured's DOB: / /

Insurance Address Insured's ID #

City: State: Zip: Policy/Group#

Health Information Reason for your visit:

Other Doctors' seen for this condition: Response:

Symptoms Started: , It is getting worse better , Pregnant: Yes No

Have you Had This in the Past Yes No Explain:

Is it painful to: Sit Walk Bend Stand Lie Down Lift Objects

Does it interfere with: Work Exercise Sleep Daily Routine Recreation

Do you take: Muscle Relaxer Pain Killers OTC Other:

Have you been treated by a Doctor of Chiropractic before Yes No

List Medical condition and surgeries:

Patient Agreement: Assignment & Release

To: Dr. Hong Zeng Yuen-Schat

1. You are authorized to **release any information** you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charge incurred.
2. I hereby authorize the **direct payment to you** of the sum I now and hereafter owe you by the insurance company. I authorize the use of this signature on all my insurance submission.

Signature of Patient 簽名

Date 日期 月 M 日 D 年 Year

ZEN Chiropractic Center

(Name): _____

(Gender): Male/Female

(Age): _____

(Date): ____/____/200__

1. (My chief complain(s) is/are, Number them if they are more than one):

- (Headache) (Stress overload) (Shoulder pain) (Back pain) (Elbow pain) (Wrist pain)
- (Jaw pain) (Hip joint pain) (Knee pain) (Ankle pain) (Neck Pain)
- (Wellness/Maintains care) (Menstrual cramping) (Pregnancy care) (Automobile accident)
- (Muscle ache) (Numbness) (Scoliosis) (Sport injury) (Frozen shoulder)
- (Ligament injury) (Torticollis) (Others)

Dr.: _____

(How did it happen):

- (Car accident) (Use computer over time) (Pregnancy) (Sport injury) (improper posture)
- (Fall) (Trauma) (Over stressed) (Unknown) (Others) _____

Dr.: _____

(Chief Complain 1)	(Chief Complain 2)	(Chief Complain 3)	(Staff Only)
(How long ago since it began): <input type="checkbox"/> (over 72 hours) <input type="checkbox"/> (within 2 wks) <input type="checkbox"/> (over 4 wks) <input type="checkbox"/> (over 1 yr)	(How long ago since it began): <input type="checkbox"/> (over 72 hours) <input type="checkbox"/> (within 2 wks) <input type="checkbox"/> (over 4 wks) <input type="checkbox"/> (over 1 yr)	(How long ago since it began): <input type="checkbox"/> (over 72 hours) <input type="checkbox"/> (within 2 wks) <input type="checkbox"/> (over 4 wks) <input type="checkbox"/> (over 1 yr)	(Cranial Nerves Test): <input type="checkbox"/> CNI <input type="checkbox"/> CNII <input type="checkbox"/> CNIII <input type="checkbox"/> CNIV <input type="checkbox"/> CNV <input type="checkbox"/> CNVI <input type="checkbox"/> CNVII <input type="checkbox"/> CNVIII <input type="checkbox"/> CNIX <input type="checkbox"/> CNX <input type="checkbox"/> CNXI <input type="checkbox"/> CNXII (Myotome):

(What will reduce the pain): <input type="checkbox"/> (None) <input type="checkbox"/> (Heat) <input type="checkbox"/> (Ice) <input type="checkbox"/> (Pain killer) <input type="checkbox"/> (Certain position) <input type="checkbox"/> (Other) Dr. _____	(What will reduce the pain): <input type="checkbox"/> (None) <input type="checkbox"/> (Heat) <input type="checkbox"/> (Ice) <input type="checkbox"/> (Pain killer) <input type="checkbox"/> (Certain position) <input type="checkbox"/> (Other) Dr. _____	(What will reduce the pain): <input type="checkbox"/> (None) <input type="checkbox"/> (Heat) <input type="checkbox"/> (Ice) <input type="checkbox"/> (Pain killer) <input type="checkbox"/> (Certain position) <input type="checkbox"/> (Other) Dr. _____	<input type="checkbox"/> C5 <input type="checkbox"/> C6 <input type="checkbox"/> C7 <input type="checkbox"/> C8 <input type="checkbox"/> T1 <input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4 <input type="checkbox"/> L5 <input type="checkbox"/> S1 (Dermatome): <input type="checkbox"/> C5 <input type="checkbox"/> C6 <input type="checkbox"/> C7 <input type="checkbox"/> C8 <input type="checkbox"/> T1 <input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4 <input type="checkbox"/> L5 <input type="checkbox"/> S1 (DTR): <input type="checkbox"/> C5 <input type="checkbox"/> C6 <input type="checkbox"/> C7 <input type="checkbox"/> L4 <input type="checkbox"/> L5 <input type="checkbox"/> S1 (Sensory Tests): <input type="checkbox"/> Sharp/Dull <input type="checkbox"/> Vibratory <input type="checkbox"/> Position <input type="checkbox"/> Babins. (Range of Motion): <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">C/S</td> <td style="width: 33%;">T/S</td> <td style="width: 33%;">L/S</td> </tr> <tr> <td>Flex. 50/ <input type="checkbox"/> Pn</td> <td>20-40/ <input type="checkbox"/> Pn</td> <td>60/ <input type="checkbox"/> Pn</td> </tr> <tr> <td>Ext. 60/ <input type="checkbox"/> Pn</td> <td>25-45/ <input type="checkbox"/> Pn</td> <td>25/ <input type="checkbox"/> Pn</td> </tr> <tr> <td>R Rot. 80/ <input type="checkbox"/> Pn</td> <td>35-50/ <input type="checkbox"/> Pn</td> <td>45/ <input type="checkbox"/> Pn</td> </tr> <tr> <td>L Rot. 80/ <input type="checkbox"/> Pn</td> <td>35-50/ <input type="checkbox"/> Pn</td> <td>45/ <input type="checkbox"/> Pn</td> </tr> <tr> <td>R Flex. 45/ <input type="checkbox"/> Pn</td> <td>20-40/ <input type="checkbox"/> Pn</td> <td>25/ <input type="checkbox"/> Pn</td> </tr> <tr> <td>L Flex 45/ <input type="checkbox"/> Pn</td> <td>20-40/ <input type="checkbox"/> Pn</td> <td>25/ <input type="checkbox"/> Pn</td> </tr> </table> (Orthopedic Tests): <input type="checkbox"/> All Neg. Except Location Note <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> </tr> <tr> <td>George's Screen</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td>Foraminal Comp.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td>Jackson's Comp.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> _____</td> </tr> <tr> <td>Max. For a. Comp.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> _____</td> </tr> </table>	C/S	T/S	L/S	Flex. 50/ <input type="checkbox"/> Pn	20-40/ <input type="checkbox"/> Pn	60/ <input type="checkbox"/> Pn	Ext. 60/ <input type="checkbox"/> Pn	25-45/ <input type="checkbox"/> Pn	25/ <input type="checkbox"/> Pn	R Rot. 80/ <input type="checkbox"/> Pn	35-50/ <input type="checkbox"/> Pn	45/ <input type="checkbox"/> Pn	L Rot. 80/ <input type="checkbox"/> Pn	35-50/ <input type="checkbox"/> Pn	45/ <input type="checkbox"/> Pn	R Flex. 45/ <input type="checkbox"/> Pn	20-40/ <input type="checkbox"/> Pn	25/ <input type="checkbox"/> Pn	L Flex 45/ <input type="checkbox"/> Pn	20-40/ <input type="checkbox"/> Pn	25/ <input type="checkbox"/> Pn		R	L	George's Screen	<input type="checkbox"/>	<input type="checkbox"/> _____	Foraminal Comp.	<input type="checkbox"/>	<input type="checkbox"/> _____	Jackson's Comp.	<input type="checkbox"/>	<input type="checkbox"/> _____	Max. For a. Comp.	<input type="checkbox"/>	<input type="checkbox"/> _____
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(When does pain feels the worst):

- (Constant)
- (Morning)
- (Afternoon)
- (Night, At rest)

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Shoulder Depress. _____

Spurling's _____

Distraction _____

Bakody _____

Swallowing _____

Valsalva _____

Dejerine's Triad _____

Sternal Comp _____

Kemp (Stand.) _____

Kemp (Seated) _____

Becherew's _____

Tripod Sign _____

SLR _____

WLR _____

Braggard's _____

Sicard's _____

Milgram's _____

Goldthwait's _____

Patrick FABERE _____

Laguerre's _____

(Staff Only)

Orthopedic Tests:

All Neg. Except Location

R L

Hibb's

Nachlas

Ely's

Yeoman's

Dr.: _____

