

**Please bring  
completed form  
to your first visit**

# Confidential Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Street Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone/Pager \_\_\_\_\_ Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Referred By \_\_\_\_\_

Work Status:     Employed     Retired     Disabled     Full-time Student     Part-time Student

Employer \_\_\_\_\_

Occupation and Job Responsibilities \_\_\_\_\_

Employer Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Family Status:     Married     Single     Divorced     Other

Spouse's Name \_\_\_\_\_  Parent: Ages of Children \_\_\_\_\_

## **In case of Emergency**

Name of relative or close friend not living in your home: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**James Otis, D.C.**  
431 30<sup>th</sup> Street  
Oakland, CA. 94609  
510-832-6848

## Signatures

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary forms to assist me in making collection from the insurance company. However, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of services.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If minor, signature of parent or guardian)

I have received a copy of Dr. Otis' Privacy Policy.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If minor, signature of parent or guardian)

### Consent of Treatment of a Minor

I hereby authorize James Otis, DC, and whomever he may so designate as his assistant, to administer Chiropractic Care as he deems necessary for my son/daughter.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**James Otis, D.C.**  
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# Health Concerns

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Right or Left Handed: \_\_\_\_\_

Please list up to 4 major health concerns in order of importance.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Please provide details about your health concerns:

- a. Describe symptoms in detail (indicate what makes them better and what makes them worse)
- b. When and how did the symptoms start?
- c. What doctors have you seen for this concern (include diagnosis, treatments prescribed, and results)
- d. What treatments have you tried, and what was the result?

Concern 1. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Concern 2. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health Concerns (Continued)

Please provide details about your health concerns:

- a. Describe symptoms in detail (indicate what makes them better and what makes them worse)
- b. When and how did the symptoms start?
- c. What doctors have you seen for this concern (include diagnosis, treatments prescribed, and results)
- d. What treatments have you tried, and what was the result?

Concern 3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Concern 4. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medical History

Please list all major illnesses, injuries, surgeries and dental procedures, from childhood to present.

<u>Age</u>	<u>Condition</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

# Family History

For the following family members, please list any known health conditions, medications, or causes of death.

Mother: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Father: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sisters/Brothers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Maternal Grandmother: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Maternal Grandfather: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Paternal Grandmother: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Paternal Grandfather: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Lifestyle

Do you smoke cigarettes?  yes  no

If yes, how many times/day: \_\_\_\_\_ days/week: \_\_\_\_\_ for how long: \_\_\_\_\_

If no, have you smoked in the past?  yes  no amount: \_\_\_\_\_ duration: \_\_\_\_\_

Do you currently consume alcohol?  yes  no type: \_\_\_\_\_ frequency: \_\_\_\_\_

Have you consumed alcohol in the past?  yes  no

type: \_\_\_\_\_ frequency: \_\_\_\_\_ duration: \_\_\_\_\_

Do you currently use recreational drugs?  yes  no

type: \_\_\_\_\_ frequency: \_\_\_\_\_

Have you used recreational drugs in the past?  yes  no

type: \_\_\_\_\_ frequency: \_\_\_\_\_ duration: \_\_\_\_\_

Do you consume caffeinated beverages?  yes  no type: \_\_\_\_\_ frequency: \_\_\_\_\_

How many times/week do you work out? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

Please describe a typical daily diet. What do you eat for:

Breakfast? \_\_\_\_\_

Lunch? \_\_\_\_\_

Dinner? \_\_\_\_\_

Snacks? \_\_\_\_\_

Please list all of the fluids that you drink each day.

\_\_\_\_\_

## Lifestyle

What are your typical hours of sleep? \_\_\_\_\_

Do you wake up with an alarm clock?  yes  no

Rate the amount of stress you are currently experiencing (0 lowest – 10 highest) \_\_\_\_\_

If high stress, what is causing stress? \_\_\_\_\_

Please rate your level of satisfaction (0 lowest – 10 highest) with the following:

Marriage/family \_\_\_\_\_ Job \_\_\_\_\_ Finances \_\_\_\_\_ Health \_\_\_\_\_



# Metabolic Assessment

Please circle the appropriate number (0-3) on all questions below. 0 = least/never 3 = most/always

## Category I

Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relief by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry or small stool	0 1 2 3
Coated tongue, or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Do you use laxatives frequently	0 1 2 3

## Category II

Excessive belching, burping or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits or vegetables; undigested foods found in stools	0 1 2 3

## Category III

Stomach pain, burning or aching 1-4 hrs after eating	0 1 2 3
Do you frequently use antacids	0 1 2 3
Feeling hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief from antacids, food, milk, carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0 1 2 3

## Category IV

Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness lasts 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side, under rib cage bloated	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

## Category V

Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Bitter, metallic taste in mouth, especially in the morning	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	yes no
Have you had your gallbladder removed	yes no

## Category VI

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to get yourself going or started	0 1 2 3
Get lightheaded if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful	0 1 2 3
Blurred vision	0 1 2 3

## Category VII

Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

## Category VIII

Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

# Metabolic Assessment (Continued)

Please circle the appropriate number (0-3) on all questions below. 0 = least/never 3 = most/always

## Category IX

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amounts of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

## Category X

Tired, sluggish	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight gain, even with low calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression, lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

## Category XI

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervousness and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

## Category XII

Diminished sex drive	0 1 2 3
Menstrual disorders of lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3

## Category XIII

Increased sex drive	0 1 2 3
Tolerance to sugars reduced	0 1 2 3
“Splitting” type headaches	0 1 2 3

## Category XIV

### (Males only)

Urination difficult or dribbling	0 1 2 3
Urination frequent	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel excavation	0 1 2 3
Leg nervousness at night	0 1 2 3

## Category XV

### (Males only)

Decrease in libido	0 1 2 3
Decrease in spontaneous morning erections	0 1 2 3
Difficulty in maintaining morning erections	0 1 2 3
Decrease in fullness of erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decrease in physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

## Category XVI

### (Menstruating Females Only)

Are you menopausal	yes	no
Alternating menstrual cycle lengths	yes	no
Extended menstrual cycle, greater than 32 days	yes	no
Shortened menses, less than 24 days	yes	no
Pain and cramping during periods	0 1 2 3	
Scanty blood flow	0 1 2 3	
Heavy blood flow	0 1 2 3	
Breast pain and swelling during menses	0 1 2 3	
Pelvic pain during menses	0 1 2 3	
Irritable and depressed during menses	0 1 2 3	
Acne breaks out	0 1 2 3	
Facial hair growth	0 1 2 3	
Hair loss/thinning	0 1 2 3	

## Category XVII

### (Menopausal Females Only)

How many years have you been menopausal ____		
Do you ever have uterine bleeding since menopause	yes	no
Hot flashes	0 1 2 3	
Mental fogginess	0 1 2 3	
Disinterest in sex	0 1 2 3	
Mood swings	0 1 2 3	
Depression	0 1 2 3	
Painful intercourse	0 1 2 3	
Shrinking breast	0 1 2 3	
Facial hair growth	0 1 2 3	
Acne	0 1 2 3	
Increased vaginal pain, dryness or itching	0 1 2 3	