Dr. Michael Cleaver, D.C.
999 Adams St., Ste. 306
St. Helena, CA 94574
(408) 313-4143

1 PATIENT INFORMATION

Date _____
Name _____
Address _____
City _____ St._____ Zip_____
E-mail _____
Driver's License # _____ State _____
Sex ❑ M ❑ F Height_____ Weight _____
Date of Birth _____ Age _____
❑ Single ❑ Married ❑ Divorced ❑ Minor
# of Children_____ Spouse (or parent)_____
Employer/School_____
Occupation _____
Employer/School Address_____
_____
Employer/School Phone (___) _____
Previous Chiropractic Care ❑ Yes ❑ No
If Yes, when? _____
Whom may we thank for referring you? _____

2 PHONE NUMBERS

Home Phone (___) _____ Cell (___)_____
Best time and place to reach you _____
_____
IN CASE OF EMERGENCY, CONTACT
Name _____Relationship_____
Home Phone _____ Work Phone _____

3 ACCIDENT INFORMATION

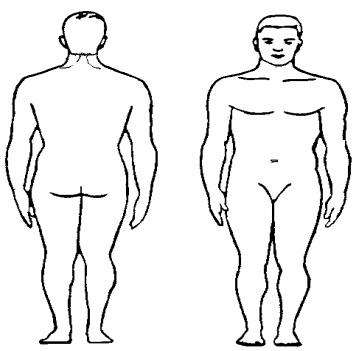
Is condition due to an accident? ❑ Yes ❑ No
If Yes, Date _____
Type of Accident ❑ Auto ❑ Work ❑ Home ❑ Other
To Whom have you made a report of your accident?
❑Auto Insurance ❑ Employer ❑ Worker Comp.
❑ Other _____
Attorney Name (If applicable) _____

4 INSURANCE INFORMATION

Insurance Co._____ Policyholder _____ Relationship to Patient_____
Address_____ City _____ State_____ Zip_____
Phone # (____)_____
Subscriber ID _____ Subscriber Date of Birth _____ Group #_____

5 PATIENT CONDITION

Reason for Visit _____
When did your symptoms appear? _____
Is this condition getting worse? ❑ Yes ❑ No ❑ Unknown
Mark an X on the picture where you have pain, numbness, tingling.
Rate severity of your pain from 0 (no pain) to 10 (severe) _____
Type of pain: ❑ Sharp ❑ Aching ❑ Stabbing ❑ Burning ❑ Numbness
❑ Dull ❑ Th
Tingling ❑ Stiffness ❑ Other
How often do you have this pain? _____
Is it constant of does it come and go? _____
Does it interfere with ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation
Activities that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down



6 HEALTH HISTORY

What treatment have you already received? ❑ Medications ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other _____

Name of other doctor(s) you have seen for this condition _____

Date of Last: Physical Exam_____ Spinal Exam_____ Spinal X-Ray_____

MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes No ❑	Diabetes	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Rheumatic Fever	❑Yes ❑No
Allergy Shots	❑ Yes No ❑	Emphysema	❑ Yes ❑ No	Measles	❑ Yes ❑ No	Scarlet Fever	❑Yes ❑No
Anemia	❑ Yes No ❑	Epilepsy	❑ Yes ❑ No	Migraines	❑ Yes ❑ No	STD's	❑Yes ❑No
Appendicitis	❑ Yes No ❑	Fractures	❑ Yes ❑ No	Miscarriage	❑ Yes ❑ No	Stroke	❑Yes ❑No
Arthritis	❑ Yes No ❑	Glaucoma	❑ Yes ❑ No	Mononucleosis	❑ Yes ❑ No	Thyroid Problems	❑Yes ❑No
Asthma	❑ Yes No ❑	Gout	❑ Yes ❑ No	Multiple Sclerosis	❑ Yes ❑ No	Tuberculosis	❑Yes ❑No
Bleeding		Heart Disease	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Tumors, Growths	❑Yes ❑No
Disorders	❑ Yes No ❑	Hepatitis	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Ulcers	❑Yes ❑No
Breast Lump	❑ Yes No ❑	Hernia	❑ Yes ❑ No	Pinched Nerve	❑ Yes ❑ No	Whooping Cough	❑Yes ❑No
Bronchitis	❑ Yes No ❑	Herniated Disc	❑ Yes ❑ No	Pneumonia	❑ Yes ❑ No	Other _____	
Cancer	❑ Yes No ❑	High Blood		Polio	❑ Yes ❑ No	_____	
Chemical		Pressure	❑ Yes ❑ No	Prostate Problem	❑ Yes ❑ No	_____	
Dependency	❑ Yes No ❑	High Cholesterol	❑ Yes ❑ No	Prosthesis	❑ Yes ❑ No	_____	
Chicken Pox	❑ Yes No ❑	Kidney Disease	❑ Yes ❑ No	Rheumatoid		_____	
				Arthritis	❑ Yes ❑ No	_____	

EXERCISE	WORK ACTIVITY	HABITS
❑ None	❑ Sitting	❑ Smoking Packs/Day_____
❑ Moderate	❑ Standing	❑ Alcohol Drinks/Week _____
❑ Daily	❑ Light Labor	❑ Coffee/Caffeine Drinks Cups/Day _____
❑ Heavy	❑ Heavy Labor	❑ High Stress Level Reason _____

Are you pregnant? ❑ Yes ❑ No Due Date_____

Injuries / Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

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MEDICATIONS	ALLERGIES	VITAMINS / MINERALS / HERBS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient / Guardian Signature: _____ Date: _____

Office Use Only

Patient / Parent / Guardian Photo Identification Verified

_____ _____

Signature **Date**