Dr. S. Kent Choi & Dr. Krista I. Koop – Cerritos Medical Center Chiropractic

Patient Information

Patient Name ______________________ Birthdate __________ Sex M / F

Address ______________________ City __________

State __________ Zip __________ Home # ( )

E-mail Address ______________________ Cell # ( )

Occupation __________ Employer __________ Work # ( )

Marital Status Single / Married / Other

Work Status Employed [Full-Time/Part-Time] / Student [F-T/P-T] / Other

Referred by: __________

Insured Information

Patient is: Primary Insurance Holder / Dependent

Name ______________________ Birthdate __________ Sex M / F

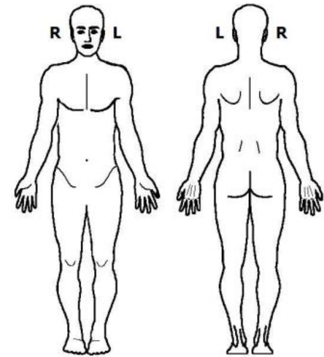
Address ______________________ City __________

State __________ Zip __________ Telephone ( )

Occupation __________ Employer __________

Insurance Carrier ______________________

Mark an **X** on the picture (below) where you have pain or other symptoms



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain

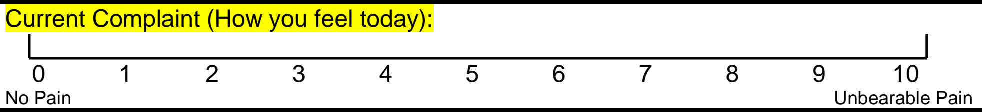
☐ Other ______________________

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began ______________________

How Problem Began ______________________

Current Complaint (How you feel today):



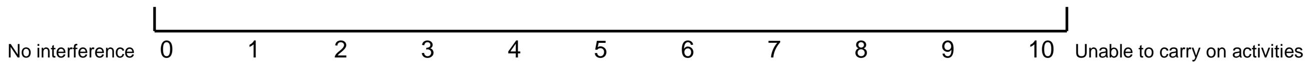
0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

How often are your symptoms present?

(Intermittent) ☐ 0 – 25% ☐ 26% - 50% ☐ 51% - 75% ☐ 76% - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities? (e.g., work, social activities, or household chores?)



No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No

☐ Yes : Date(s) taken: __________ What areas were taken? __________

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) __________
☐ Corticosteroid Use (cortisone, prednisone, etc)
☐ Taking Birth Control Pills
☐ Dizziness/ Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) __________
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) __________

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant: # weeks __________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries __________
☐ Medications __________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact y physicians, if necessary.

Patient Signature ______________________ Date __________