

# Life Chiropractic/Back In Action

Bruce D. Stevens D.C.

217-A West Central, Lompoc CA 93436 • 805-737-5656

Name: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Drivers License or ID #: \_\_\_\_\_ State: \_\_\_\_\_

Single  Married  Divorced  Widow Number of Children \_\_\_\_\_

Are you pregnant  Yes  No Height: \_\_\_\_\_ Weight: \_\_\_\_\_



Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_



Are you covered by health insurance?  Yes  No

*\*If yes, please give your card to the Front Desk so they may get a copy.*

Name of Insurance: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Member/ID #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_



Is this injury work related?  Yes  No

Is this injury a result of an Auto Accident?  Yes  No

*\*If you answered yes to either of the above questions please let the Front Desk know immediately.*



How were you referred to our office? \_\_\_\_\_

Have you ever had chiropractic care before?  Yes  No

If yes, when and where? \_\_\_\_\_



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Please list your chief complaints in order of severity (pain, symptoms, etc)

1. \_\_\_\_\_ For how long? \_\_\_\_\_
2. \_\_\_\_\_ For how long? \_\_\_\_\_
3. \_\_\_\_\_ For how long? \_\_\_\_\_

Please list other doctors consulted for this condition:  N/A

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

How did this condition develop? What caused it? (fall, lifting, etc)

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

Date on injury: \_\_\_\_\_

Has this problem been getting  Better  Worse  Staying the same

Is there anything you do that makes your condition worse?  Yes  No

If yes, please list: \_\_\_\_\_

Have you ever had any surgery/hospitalizations?  Yes  No

If yes, please list: \_\_\_\_\_

Please list injuries or illness that you have had in the past that are not listed above:

\_\_\_\_\_

Medication you now take  Aspirin/Tylenol  Painkillers  Muscle Relaxers

Tranquilizers  Insulin  Birth Control Pills

Other (please list) \_\_\_\_\_