



# CONFIDENTIAL HEALTH INFORMATION

**GENESIS CFH**  
**Dr. Jason Stoddard, D.C.**  
1777 N Bellflower Blvd, # 107  
Long Beach, CA 90815  
(562)280-3770  
genesiscfh.com

Please allow our staff to photocopy your driver's license and insurance details.  
All information you supply is confidential. We comply with all federal privacy standards.  
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

No  Yes

Whom may we thank for referring you?

When?

If so, whom?

Age

Gender  
 Male  Female

Race  
 American Indian  Alaskan Native  Asian  Black or African American  
 Native Hawaiian  Other Pacific Islander  Other  White  
 Decline to answer

Ethnicity  
 Hispanic or Latino  
 Not Hispanic or Latino  
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

Never A Smoker  Former Smoker  
 Current Every Day Smoker  Current Some Day Smoker  
 Heavy Smoker  Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status  Married  
 Single  Divorced  
 Widowed  Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes  No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone  Cell Phone  
 Work Phone  Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self  Spouse  Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

**Primary Complaint**

The primary symptom that prompted me to seek care today is: \_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

- A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Secondary Complaint**

The secondary symptom that prompted me to seek care today is: \_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

- A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Additional Complaint**

The additional symptom that prompted me to seek care today is: \_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

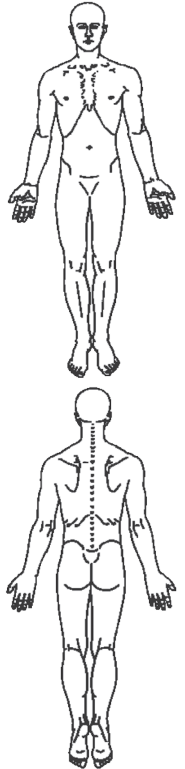
- A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Location**  
 (Where does it hurt?)  
 Circle the area(s) on the illustration.  
 "O" for current condition  
 "X" for conditions experienced in the past



1. What else should Dr. Stoddard know about your current condition? \_\_\_\_\_

2. How does your current condition interfere with your:

Work or career: \_\_\_\_\_

Recreational activities: \_\_\_\_\_

Household responsibilities: \_\_\_\_\_

Personal relationships: \_\_\_\_\_

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis                   | <input type="radio"/> Arthritis                      | <input type="radio"/> Scoliosis                      | <input type="radio"/> Neck pain                      | <input type="radio"/> Back problems                  | <input type="radio"/> Hip disorders                  | Initials _____             |
| <input type="radio"/> Knee injuries                  | <input type="radio"/> Foot/ankle pain                | <input type="radio"/> Shoulder problems              | <input type="radio"/> Elbow/wrist pain               | <input type="radio"/> TMJ issues                     | <input type="radio"/> Poor posture                   |                            |

b. Neurological

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety                        | <input type="radio"/> Depression                     | <input type="radio"/> Headache                       | <input type="radio"/> Dizziness                      | <input type="radio"/> Pins and needles               | <input type="radio"/> Numbness                       | Initials _____             |

c. Cardiovascular

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure            | <input type="radio"/> Low blood pressure             | <input type="radio"/> High cholesterol               | <input type="radio"/> Poor circulation               | <input type="radio"/> Angina                         | <input type="radio"/> Excessive bruising             | Initials _____             |

d. Respiratory

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma                         | <input type="radio"/> Apnea                          | <input type="radio"/> Emphysema                      | <input type="radio"/> Hay fever                      | <input type="radio"/> Shortness of breath            | <input type="radio"/> Pneumonia                      | Initials _____             |

e. Digestive

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia               | <input type="radio"/> Ulcer                          | <input type="radio"/> Food sensitivities             | <input type="radio"/> Heartburn                      | <input type="radio"/> Constipation                   | <input type="radio"/> Diarrhea                       | Initials _____             |

f. Sensory

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision                 | <input type="radio"/> Ringing in ears                | <input type="radio"/> Hearing loss                   | <input type="radio"/> Chronic ear infection          | <input type="radio"/> Loss of smell                  | <input type="radio"/> Loss of taste                  | Initials _____             |

g. Skin

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer                    | <input type="radio"/> Psoriasis                      | <input type="radio"/> Eczema                         | <input type="radio"/> Acne                           | <input type="radio"/> Hair loss                      | <input type="radio"/> Rash                           | Initials _____             |

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Patient Number  
(office use only)

\_\_\_\_\_  
Doctor's Initials

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**h. Endocrine**

- Had  Have  Thyroid issues    Had  Have  Immune disorders    Had  Have  Hypoglycemia    Had  Have  Frequent infection    Had  Have  Swollen glands    Had  Have  Low energy    NONE

Initials \_\_\_\_\_

**i. Genitourinary**

- Had  Have  Kidney stones    Had  Have  Infertility    Had  Have  Bedwetting    Had  Have  Prostate issues    Had  Have  Erectile dysfunction    Had  Have  PMS symptoms    NONE

Initials \_\_\_\_\_

**j. Constitutional**

- Had  Have  Fainting    Had  Have  Low libido    Had  Have  Poor appetite    Had  Have  Fatigue    Had  Have  Sudden weight gain/loss (circle one)    Had  Have  Weakness    NONE

Initials \_\_\_\_\_

Patient name \_\_\_\_\_

Patient Number (office use only) \_\_\_\_\_

All other systems negative

**Past Personal, Family and Social History**

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

|  |   |  |   |
|--|---|--|---|
| <b>PERSONAL</b>                                    | <b>4. Illnesses</b><br>Check the illnesses you have <b>Had</b> in the past or <b>Have</b> now.  | <b>5. Operations</b><br>Surgical interventions, which may or may not have included hospitalization.                | <b>6. Treatments</b><br>Check the ones you've received in the <b>Past</b> or are receiving <b>Currently</b> . |
|  | Had <input type="radio"/> Have <input type="radio"/> AIDS    Had <input type="radio"/> Have <input type="radio"/> Tuberculosis              | <input type="radio"/> Appendix removal   | <b>Past</b> <b>Currently</b>  |
|  | <input type="radio"/> Alcoholism <input type="radio"/> Typhoid fever  | <input type="radio"/> Bypass surgery   | <input type="radio"/> Acupuncture   |
|  | <input type="radio"/> Allergies <input type="radio"/> Ulcer   | <input type="radio"/> Cancer   | <input type="radio"/> Antibiotics   |
|  | <input type="radio"/> Arteriosclerosis <input type="radio"/> Other: _____   | <input type="radio"/> Cosmetic surgery   | <input type="radio"/> Birth control pills   |
|  | <input type="radio"/> Chicken pox   | <input type="radio"/> Elective surgery: _____  | <input type="radio"/> Blood transfusions  |
|  | <input type="radio"/> Diabetes  | <input type="radio"/> Eye surgery  | <input type="radio"/> Chemotherapy  |
|  | <input type="radio"/> Epilepsy  | <input type="radio"/> Hysterectomy   | <input type="radio"/> Chiropractic care   |
|  | <input type="radio"/> Glaucoma  | <input type="radio"/> Pacemaker  | <input type="radio"/> Dialysis  |
|  | <input type="radio"/> Goiter  | <input type="radio"/> Spine _____  | <input type="radio"/> Herbs   |
| <input type="radio"/> Gout                         | _____   | <input type="radio"/> Homeopathy   |   |
| <input type="radio"/> Heart disease                | _____   | <input type="radio"/> Hormone replacement  |   |
| <input type="radio"/> Hepatitis                    | _____   | <input type="radio"/> Inhaler  |   |
| <input type="radio"/> HIV Positive                 | _____   | <input type="radio"/> Massage therapy  |   |
| <input type="radio"/> Malaria                      | _____   | <input type="radio"/> Physical therapy   |   |
| <input type="radio"/> Measles                      | _____   | <input type="radio"/> Medications  |   |
| <input type="radio"/> Multiple Sclerosis           | _____   | (Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____ |   |
| <input type="radio"/> Mumps                        | _____   | _____  |   |
| <input type="radio"/> Polio                        | _____   | _____  |   |
| <input type="radio"/> Rheumatic fever              | _____   | _____  |   |
| <input type="radio"/> Scarlet fever                | _____   | _____  |   |
| <input type="radio"/> Sexually transmitted disease | _____   | _____  |   |
| <input type="radio"/> Stroke                       | _____   | _____  |   |
|  | <b>7. Allergies</b><br>Are you allergic to any medications?<br>Yes <input type="radio"/> No <input type="radio"/> If Yes please list: _____ | <input type="radio"/> Tonsillectomy  | _____   |
|  | <b>8. Injuries</b><br>Have you ever...  | <input type="radio"/> Vasectomy  | _____   |
|  | <input type="radio"/> Had a fractured or broken bone  | <input type="radio"/> Other: _____   | _____   |
|  | <input type="radio"/> Had a spine or nerve disorder   | _____  | _____   |
|  | <input type="radio"/> Been knocked unconscious  | <input type="radio"/> Used a crutch or other support   | _____   |
|  | <input type="radio"/> Been injured in an accident   | <input type="radio"/> Used neck or back bracing  | _____   |
|  |   | <input type="radio"/> Received a tattoo  | _____   |
|  |   | <input type="radio"/> Had a body piercing  | _____   |

Consultation Notes

**9. Family History**

Some health issues are hereditary. Tell Dr. Stoddard about the health of your immediate family members.

|               | Relative  | Age (If living) | State of health       |                       | Illnesses | Age at death | Cause of death        |                       |
|---------------|-----------|-----------------|-----------------------|-----------------------|-----------|--------------|-----------------------|-----------------------|
|               |           |                 | Good                  | Poor                  |           |              | Natural               | Illness               |
| <b>FAMILY</b> | Mother    | _____           | <input type="radio"/> | <input type="radio"/> | _____     | _____        | <input type="radio"/> | <input type="radio"/> |
|               | Father    | _____           | <input type="radio"/> | <input type="radio"/> | _____     | _____        | <input type="radio"/> | <input type="radio"/> |
|               | Sister 1  | _____           | <input type="radio"/> | <input type="radio"/> | _____     | _____        | <input type="radio"/> | <input type="radio"/> |
|               | Sister 2  | _____           | <input type="radio"/> | <input type="radio"/> | _____     | _____        | <input type="radio"/> | <input type="radio"/> |
|               | Brother 1 | _____           | <input type="radio"/> | <input type="radio"/> | _____     | _____        | <input type="radio"/> | <input type="radio"/> |
|               | Brother 2 | _____           | <input type="radio"/> | <input type="radio"/> | _____     | _____        | <input type="radio"/> | <input type="radio"/> |

**10. Are there any other hereditary health issues that you know about?** \_\_\_\_\_

**11. Social History**

Tell Dr. Stoddard about your health habits and stress levels.

|               |                |  |                 |                       |  |
|---------------|----------------|--|-----------------|-----------------------|--|
| <b>SOCIAL</b> | Alcohol use    | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Prayer or meditation? | <input type="radio"/> Yes <input type="radio"/> No |
|               | Coffee use     | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Job pressure/stress?  | <input type="radio"/> Yes <input type="radio"/> No |
|               | Tobacco use    | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Financial peace?      | <input type="radio"/> Yes <input type="radio"/> No |
|               | Exercising     | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Vaccinated?           | <input type="radio"/> Yes <input type="radio"/> No |
|               | Pain relievers | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Mercury fillings?     | <input type="radio"/> Yes <input type="radio"/> No |
|               | Soft drinks    | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Recreational drugs?   | <input type="radio"/> Yes <input type="radio"/> No |
|               | Water intake   | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ |                       |  |
|               | Hobbies:       | _____  |                 |                       |  |

Doctor's Initials \_\_\_\_\_

**GENESIS CFH**  
**Dr. Jason Stoddard, D.C.**

**12. Activities of Daily Living**

How does this condition currently interfere with your life and ability to function?

|                       | No Effect             | Mild Effect           | Moderate Effect       | Severe Effect         |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Sitting               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rising out of chair   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Standing              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Walking               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Lying down            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Bending over          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Climbing stairs       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Using a computer      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Getting in/out of car | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Driving a car         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Looking over shoulder | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Caring for family     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

|                      | No Effect             | Mild Effect           | Moderate Effect       | Severe Effect         |
|----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Grocery shopping     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Household chores     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Lifting objects      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Reaching overhead    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Showering or bathing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Dressing myself      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Love life            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Getting to sleep     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Staying asleep       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Concentrating        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Exercising           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Yard work            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Patient name \_\_\_\_\_

Patient Number  
(office use only) \_\_\_\_\_

13. What is the major stressor in your life? \_\_\_\_\_ 14. How much sleep do you average per night? \_\_\_\_\_ Hours

15. What is the type and approximate age of your mattress and pillow? \_\_\_\_\_ 16. What is your preferred sleeping position? \_\_\_\_\_

17. Describe your typical eating habits:  Skip breakfast  Two meals a day  Three meals a day  Snacking between meals

18. What would be the most significant thing that you could do to improve your health? \_\_\_\_\_

19. In addition to the main reason for your visit today, what additional health goals do you have? \_\_\_\_\_

**Acknowledgements**

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials \_\_\_\_\_ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials \_\_\_\_\_ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials \_\_\_\_\_ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): \_\_\_\_\_**

Initials \_\_\_\_\_ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials \_\_\_\_\_ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials \_\_\_\_\_ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Consultation Notes

Doctor's Initials \_\_\_\_\_

GENESIS CFH  
Dr. Jason Stoddard, D.C.

\_\_\_\_\_  
Patient (or Guardian's) signature

\_\_\_\_\_  
Date (MM/DD/YYYY)