DEAN GUIDA, D.C.
2536 KILAUEA AVENUE
HILO, HAWAII 96720
PHONE: 808.938.5257 FAX: 808.204.9052

Date: _____ Name: _____

Street: _____ City: _____ State: _____ Zip : _____

Age: _____ Birthdate: _____ Marital status: **S M W D** No. of Children: _____

Social security number: _____ Email address: _____

Occupation: _____ Employer: _____

Home phone number: _____ Work/Cell: _____

How did you hear about our office? _____

Present complaints: _____

How long have you had this: _____ Is your pain? **SHARP DULL ACHY BURNING**

Other professionals consulted for your present condition: _____

Past surgeries and dates: _____

Is your condition related to? **AUTO ACCIDENT WORKERS COMP. SLIP/FALL**

Date of accident or injury: _____

History of broken bones: _____

Medication presently taking: _____

_____

Present family doctor: _____ Phone: _____

Health Insurance Carrier: _____ Phone: _____

Health Insurance Billing address: _____

Name of Insured: _____ Relationship to patient: _____

Insurance ID # _____ Group # _____

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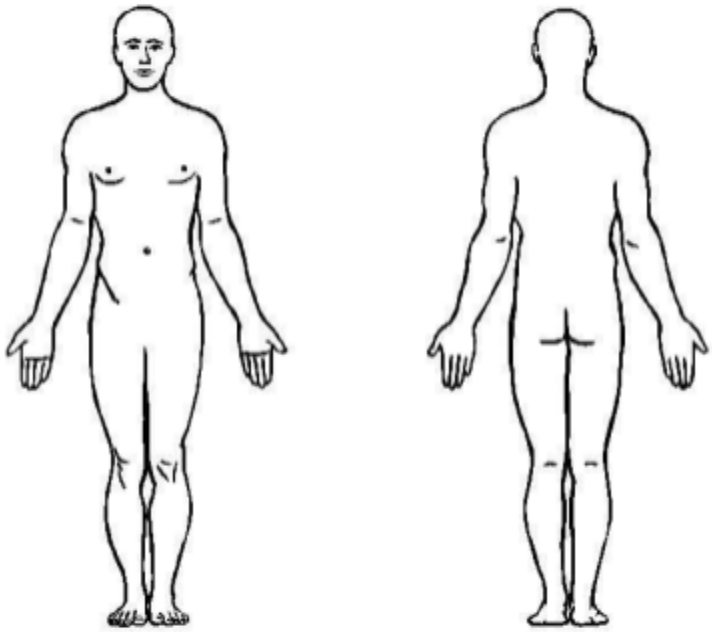
PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS AND MARK AREAS AFFECTED ON THE DIAGRAM BELOW:

____ **HEADACHES**
____ **EYE/ SINUS PAIN**
____ **FACIAL PAIN**
____ **RINGING IN THE EAR**
____ **RESTRICTED NECK MOVEMENT**
____ **NECK PAIN**
____ **NECK SPASMS**
____ **POOR POSTURE**
____ **SHOULDER / ARM / HAND PAIN**
____ **PAINFUL / STIFF JOINTS**
____ **RESTRICTED SHOULDER/ ARM MOVEMENT**
____ **BURSITIS/ TENDONITIS**
____ **PAIN UNDER SHOULDER BLADE/ SCAPULA**
____ **PAIN AROUND COLLAR BONE/ CLAVICLE**
____ **UPPER BACK PAIN**
____ **MID BACK PAIN**
____ **CHEST PAIN**
____ **DIFFICULTY BREATHING**
____ **RIB CAGE PAIN**
____ **RESTRICTED TORSO MOVEMENT**
____ **SCOLIOSIS/ CURVATURE OF THE SPINE**
____ **SUBLUXATIONS / PINCHED NERVES**
____ **LOWER BACK PAIN**
____ **SCIATICA / PAIN RADIATING DOWN THE LEG**
____ **NUMBNESS IN ARMS HANDS LEGS OR FEET**
____ **PAIN IN THE BUTTOCKS**
____ **HIP PAIN**
____ **RESTRICTED LEG MOVEMENTS**
____ **LEG CRAMPS**
____ **LEG PAIN UPPER AND LOWER**
____ **FOOT / TOE PAIN**
____ **SORE / WEAK MUSCLES**



I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Guida's office will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid to Dr. Dean Guida be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

PATIENT'S SIGNATURE: _____ DATE: _____