

# Confidential Patient Information

Patient Name:				Today's Date	
Street Address			Birth Date		Age
					Sex <input type="radio"/> F <input type="radio"/> M
City		State	Zip		Social Security #
Marital Status <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widow		Spouse Name			# of Children
Home Phone		Work Phone	Cell Phone		Best place to reach you: <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell
E-mail			Whom may we thank for referring you here?		
Occupation			Employer		
Emergency Contact Name			Emergency Contact Phone #		

## The Reason You're Here

The symptom(s) that have prompted me to seek care today include:

When did this problem/pain start? \_\_\_\_\_  Gradual  Sudden

What do you think caused this problem? \_\_\_\_\_

How are your symptoms changing?  Getting better  Not changing  Getting worse

What helps? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Have you had similar conditions/symptoms in the past?  No  Yes.

If yes, when? \_\_\_\_\_

Have you been to a chiropractor before?  No  Yes - date of last adjustment \_\_\_\_\_

Who else have you seen for this? \_\_\_\_\_

What other care have you received for this? \_\_\_\_\_

Have you had spinal x-rays taken within the last year?  No  Yes.

If yes, was it for the same problem?  Yes  No

Please add anything else you would like the doctor to know about your current condition

## Your Current Health

Do you exercise?  No  Yes. How often? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

Check those that apply:  Smoke \_\_\_\_\_ packs/day.  Alcohol \_\_\_\_\_ drinks/week.

Coffee \_\_\_\_\_ cups/week.

Rate your stress: low medium high      Rate your diet: healthy average poor

Please check if you are currently involved in any of the following activities:

Commute / Drive In Car ( \_\_\_\_\_ hrs/day)       Play Video Games ( \_\_\_\_\_ hrs/day)

Computer Use ( \_\_\_\_\_ hrs/day)       Watch Television ( \_\_\_\_\_ hrs/day)

Read/watch TV in Bed       Sleep on stomach

Consultation Notes

\_\_\_\_\_  
Drs Initials

Please list all medications and nutritional supplements:

WOMEN ONLY: Are you pregnant?  No  Yes, Due Date \_\_\_\_\_  
Date of Last period \_\_\_\_\_  
Please check if you have or have had any of the following:  
 PMS  Irregular cycle  Unable to get pregnant

Your Health History

Have you been treated for any health condition in the last year?  Yes  No  
If yes, please explain: \_\_\_\_\_

Please list any previous accidents and dates ( ie. auto, work, falls, broken bones, spinal injuries, etc):

Please describe any hospitalizations & surgeries (other than above):

If you have experienced any of the following conditions in the past, mark a "P" on the line provided. If you are currently experiencing any of the following conditions, please mark a "C" on the line provided. Check all that apply.

- \_\_\_ heart attack \_\_\_ anemia \_\_\_ migraine
\_\_\_ diabetes \_\_\_ ulcers \_\_\_ syphilis
\_\_\_ difficulty with urination \_\_\_ loss of memory \_\_\_ asthma
\_\_\_ prostate trouble \_\_\_ muscle cramping \_\_\_ shortness of breath
\_\_\_ AIDS \_\_\_ headache \_\_\_ sudden weight loss
\_\_\_ incontinence \_\_\_ tuberculosis \_\_\_ loss of hearing
\_\_\_ pelvic organ prolapse \_\_\_ arthritis \_\_\_ epilepsy
\_\_\_ constipation \_\_\_ fainting spells \_\_\_ sprained ankle
\_\_\_ nausea/morning \_\_\_ dizziness \_\_\_ right left
sickness \_\_\_ difficulty with bowel \_\_\_ muscle weakness
\_\_\_ ears ringing \_\_\_ movements \_\_\_ walking problems
\_\_\_ gout \_\_\_ cancer \_\_\_ numbness
\_\_\_ knee/hip replacement \_\_\_ diverticulosis \_\_\_ jaw pain
\_\_\_ stroke \_\_\_ chest pain \_\_\_ chest pain / arm pain
\_\_\_ glaucoma \_\_\_ general fatigue
\_\_\_ bloody stools \_\_\_ soreness in joints

all other systems negative

\_\_\_\_\_  
Drs Initials

Please add anything else you would like the doctor to know: \_\_\_\_\_

Authorization I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorized this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

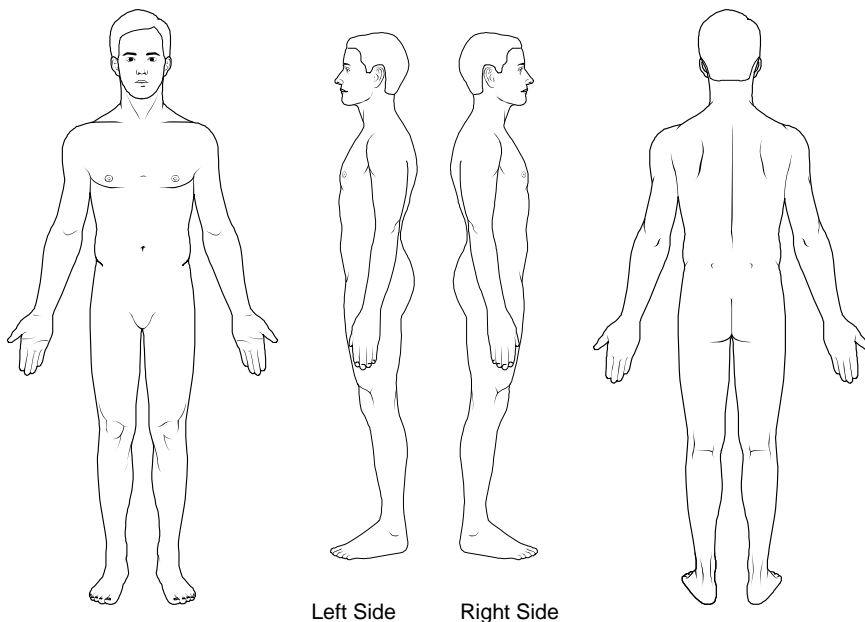
Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(signature of parent if patient is a minor)

# Pain Drawing & Quadruple Index

Name: \_\_\_\_\_ Date: \_\_\_\_\_

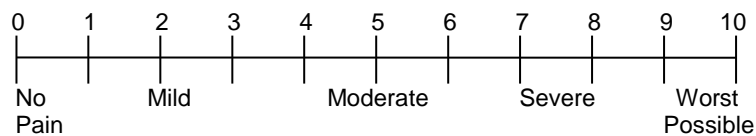
**1. Mark these drawings according to where you hurt** (If the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). **Please indicate which sensations you feel by referring to the key below.**

KEY	
Stabbing	//////////
Burning	XXXXXXXX
Pins & Needles	OOOOOO
Aching	++++++
Numbness	=====

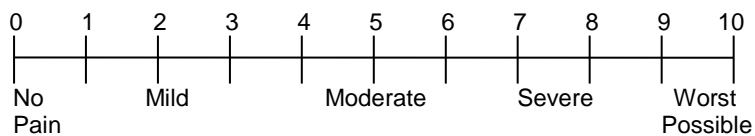


**2. On the FOUR scales below, please draw a vertical line representing your pain or discomfort.**

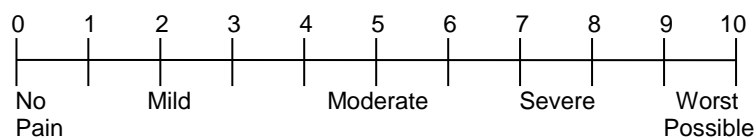
**A. Rate the pain you have RIGHT NOW:**



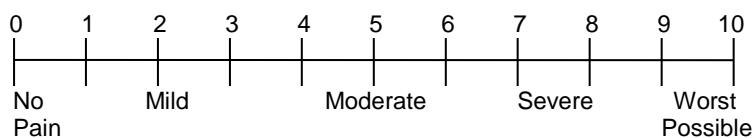
**B. Rate your AVERAGE pain in the past week:**



**C. Rate your pain at its BEST in the past week:**



**D. Rate your WORST pain in the past week:**



Consultation Notes

\_\_\_\_\_  
Drs Initials

# Activities of Daily Living

Name: \_\_\_\_\_

Date: \_\_\_\_\_

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition RIGHT NOW.

Pain Intensity

- |          |           |               |             |                     |
|----------|-----------|---------------|-------------|---------------------|
| <b>0</b> | <b>1</b>  | <b>2</b>      | <b>3</b>    | <b>4</b>            |
| No Pain  | Mild pain | Moderate pain | Severe pain | Worst possible pain |

Recreation

- |                       |                        |                        |                         |                          |
|-----------------------|------------------------|------------------------|-------------------------|--------------------------|
| <b>0</b>              | <b>1</b>               | <b>2</b>               | <b>3</b>                | <b>4</b>                 |
| Can do All Activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities |

Sleeping

- |               |                        |                            |                         |                         |
|---------------|------------------------|----------------------------|-------------------------|-------------------------|
| <b>0</b>      | <b>1</b>               | <b>2</b>                   | <b>3</b>                | <b>4</b>                |
| Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep |

Frequency of Pain

- |          |                                 |                                   |                               |                                |
|----------|---------------------------------|-----------------------------------|-------------------------------|--------------------------------|
| <b>0</b> | <b>1</b>                        | <b>2</b>                          | <b>3</b>                      | <b>4</b>                       |
| No pain  | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

Personal Care (washing, dressing, etc.)

- |                          |                            |                                  |                                     |                                   |
|--------------------------|----------------------------|----------------------------------|-------------------------------------|-----------------------------------|
| <b>0</b>                 | <b>1</b>                   | <b>2</b>                         | <b>3</b>                            | <b>4</b>                          |
| No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance |

Lifting

- |                           |                                  |                                     |                                  |                                |
|---------------------------|----------------------------------|-------------------------------------|----------------------------------|--------------------------------|
| <b>0</b>                  | <b>1</b>                         | <b>2</b>                            | <b>3</b>                         | <b>4</b>                       |
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight |

Travel (driving, etc.)

- |                       |                         |                             |                              |                           |
|-----------------------|-------------------------|-----------------------------|------------------------------|---------------------------|
| <b>0</b>              | <b>1</b>                | <b>2</b>                    | <b>3</b>                     | <b>4</b>                  |
| No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on long trips |

Walking

- |                       |                             |                             |                             |                                 |
|-----------------------|-----------------------------|-----------------------------|-----------------------------|---------------------------------|
| <b>0</b>              | <b>1</b>                    | <b>2</b>                    | <b>3</b>                    | <b>4</b>                        |
| No pain; any distance | Increased pain after 1 mile | Increased pain after ½ mile | Increased pain after ¼ mile | Increased pain with all walking |

Work

- |   |                                  |                          |                          |             |
|---|----------------------------------|--------------------------|--------------------------|-------------|
| <b>0</b>                                    | <b>1</b>                         | <b>2</b>                 | <b>3</b>                 | <b>4</b>    |
| Can do Usual work Plus unlimited Extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work |

Standing

- |                             |                                    |                             |                             |                                  |
|-----------------------------|------------------------------------|-----------------------------|-----------------------------|----------------------------------|
| <b>0</b>                    | <b>1</b>                           | <b>2</b>                    | <b>3</b>                    | <b>4</b>                         |
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after ½ hour | Increased pain with any standing |

Consultation Notes

\_\_\_\_\_ FRI Score

\_\_\_\_\_ Drs Initials