Confidential Health Information

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

Primary and Additional Complaints

The **PRIMARY** symptom that prompted me to seek care today:

____

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

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ADDITIONAL symptom(s) that prompted me to seek care today:

____

Social History

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)
❍ Computer Use (_____ hrs/day)
❍ Read/watch TV in Bed
❍ Play Video Games (_____ hrs/day)
❍ Watch Television (_____ hrs/day)
❍ Sleep on stomach

Consultation Notes

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Drs Initials

Please list all medications and nutritional supplements: ____________________

Consultation Notes

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

Past 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): ____________________

Review of Systems

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

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

❍ all other systems negative

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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:** ____________

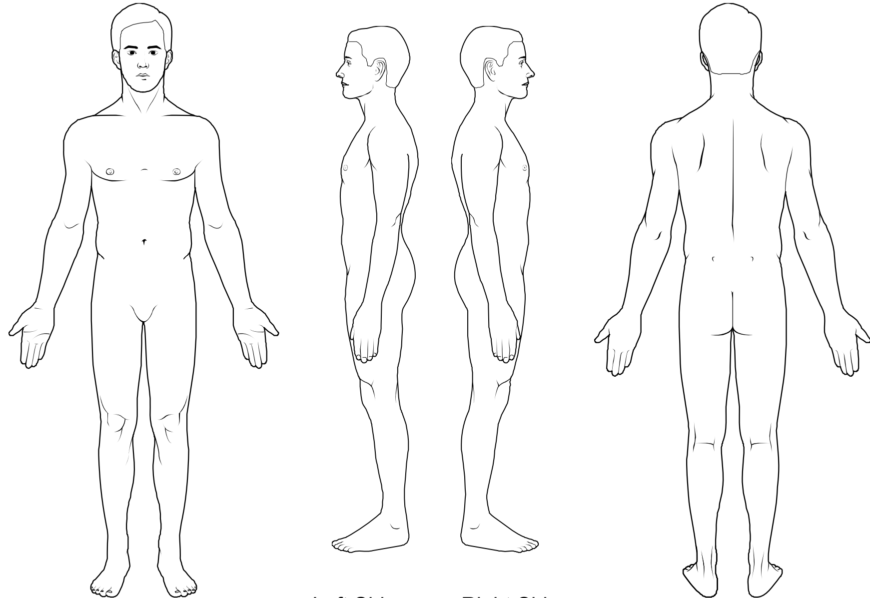
(signature of parent if patient is a minor)

Pain Drawing & Quadruple Index

Name____ **Date**____________

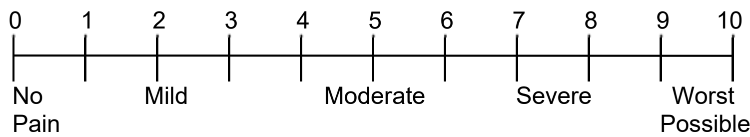
1. **Mark these drawings according to where you hurt** (If the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). **Please indicate which sensations you feel by referring to the key below.**

KEY	
Stabbing	/ / / / / / / / / /
Burning	X X X X X X
Pins & Needles	O O O O O
Aching	+ + + + + +
Numbness	= = = = = =

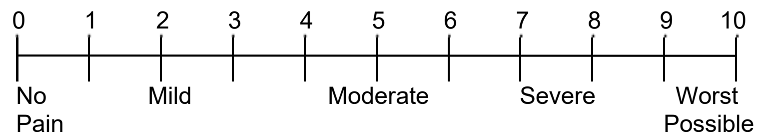


2. On the **FOUR** scales below, **please draw a vertical line** representing your pain or discomfort.

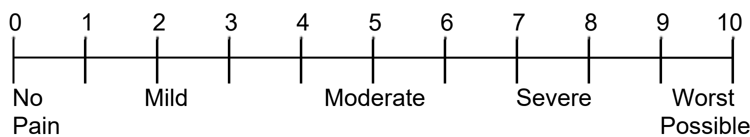
A. Rate the pain you have **RIGHT NOW:**



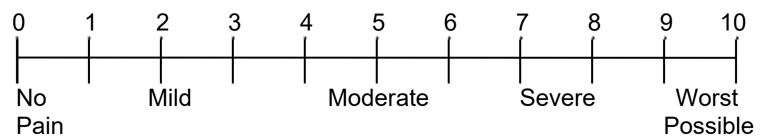
B. Rate your **AVERAGE** pain in the past week:



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



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



Consultation Notes

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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

0	1	2	3	4
No Pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

Personal Care (washing, dressing, etc)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

Travel (driving, etc.)

0	1	2	3	4
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

Work

0	1	2	3	4
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

Recreation

0	1	2	3	4
Can do All Activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

Frequency of Pain

0	1	2	3	4
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

Lifting

0	1	2	3	4
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

Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

Standing

0	1	2	3	4
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

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Consultation Notes

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FRI Score

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