What's New?

For the top portion (phone, address, etc.), please let us know if any of your info has changed.
If nothing has changed, you can leave the top portion blank.

Name				Date
Street Address			Home Phone	Work Phone
City	State	Zip	Cell Phone	Best place to reach you: ❍ Home ❍ Work ❍ Cell
Marital Status ❍ Married ❍ Single ❍ Divorced ❍ Seperated ❍ Widow		Spouse Name		# of Children
E-mail				
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? _____

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

Consultation Notes

_____
Drs Initials

Name_____ **Date**_____

Please list all medications and nutritional supplements:

_____

_____

Please indicate if you are currently experiencing any of the following:

❍ Jaw pain / clicking	❍ Cold / tingling extremities	❍ Fatigue	❍ Allergies
❍ Arthritis	❍ Muscle Weakness	❍ Fainting	❍ Dizziness
❍ Walking problems	❍ Headache	❍ Cancer	❍ Numbness
❍ Chest pain / Arm pain	❍ Bowel/Bladder Dysfunction	❍ Stomach problems	❍ Fever

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

_____

_____

WOMEN ONLY: Are you pregnant? ❍ No ❍ Yes, Due Date _____

Please check if you have or have had any of the following: ❍ PMS ❍ Irregular cycle

Date of Last period _____ ❍ Unable to get pregnant

Consultation Notes

❍ all other systems negative

_____
Drs Initials

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**_____

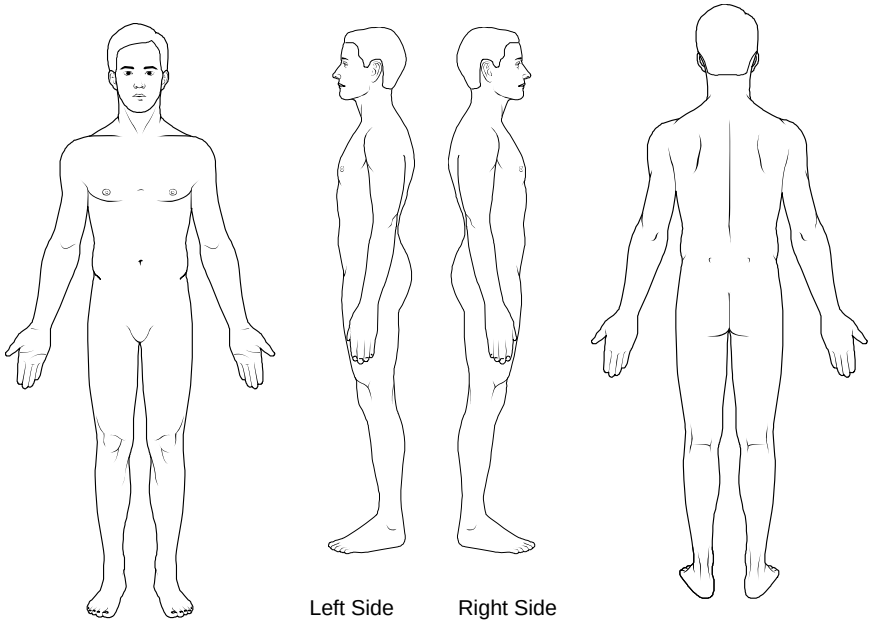
(signature of parent if patient is a minor)

Pain Drawing & Quadruple Index

Name_____ **Date**_____

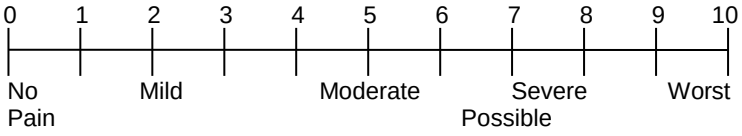
1. **Mark these drawings according to where you hurt** (If the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). **Please indicate which sensations you feel by referring to the key below.**

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

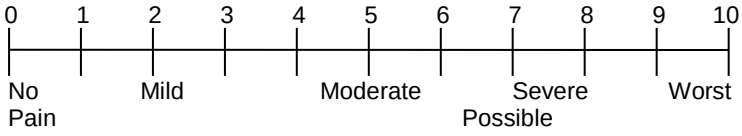


2. On the **FOUR** scales below, **please draw a vertical line** representing your pain or discomfort.

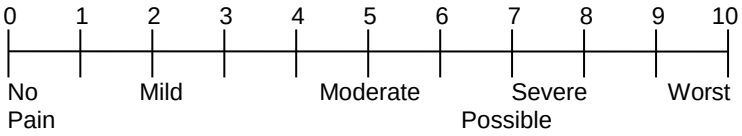
A. Rate the pain you have **RIGHT NOW:**



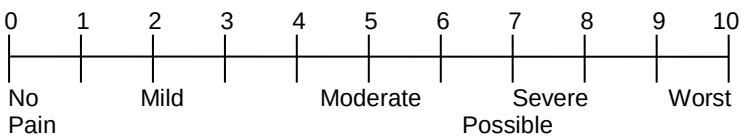
B. Rate your **AVERAGE** pain in the past week:



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



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



Consultation Notes

_____
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

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

_____
FRI Score

_____
Drs Initials