CONFIDENTIAL PATIENT INFORMATION

NAME:_____ DATE:_____

HOME PHONE:_____WORK PHONE:_____

STREET ADDRESS:_____

CITY/STATE:_____ZIP:_____P.O. BOX_____

AGE:_____DATE OF BIRTH:_____# OF CHILDREN:_____

MARITAL STATUS: **S M W D**

E-MAIL ADDRESS:_____GENDER: M ☐ F ☐

NAME OF EMPLOYER:_____

OCCUPATION:_____HOW DID YOU HEAR ABOUT US?_____

NAME OF SPOUSE:_____OCCUPATION:_____

NEAREST RELATIVE:_____PHONE:_____

ADDRESS:_____

CITY/STATE:_____ZIP CODE:_____

ARE YOU PREGNANT? YES ☐ NO ☐ PLEASE INITIAL HERE_____

WERE YOU INJURED ON THE JOB? YES ☐ NO ☐

WERE YOU INJURED IN AN AUTO ACCIDENT? YES ☐ NO ☐

PURPOSE OF THIS APPOINTMENT/MAJOR COMPLAINT (please describe):_____

_____

_____

_____

WHEN DID IT START?_____

SYMPTOMS	SEVERITY (0=NO PAIN 10=EMERGENCY)
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

HAVE YOU LOST ANY DAYS FROM SCHOOL/WORK? YES ☐ NO ☐

DATES IF TIME LOST:_____

HAVE YOU EVER HAD THIS PROBLEM BEFORE? YES ☐ NO ☐

IF SO, WHEN?_____IS THIS CONDITION WORSENING ☐STAYING THE SAME ☐ IMPROVING ☐

WHAT MAKES YOUR SYMPTOMS WORSE?_____

DID YOU CONSULT OTHER DOCTORS FOR THIS CONDITION? YES ☐ NO ☐

NAMES AND DATES?_____

THEIR DIAGNOSIS:_____RESULTS:_____

ARE YOU TAKING MEDICATION? YES ☐ NO ☐

IF SO, WHAT KIND?_____

HAVE YOU HAD ANY BROKEN BONES? YES ☐ NO ☐

PLEASE LIST:_____

PLEASE LIST ANY PAST ACCIDENTS OR FALLS:_____

_____

_____

DATE OF LAST PHYSICAL EXAM:_____CHIROPRACTIC EXAM: _____

_____

HEIGHT:_____WEIGHT:_____DATE OF LAST MENSUS:_____

_____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER: YES ☐ NO ☐

WHEN?_____WHAT TYPE?_____

ANY HISTORY OF CANCER IN YOUR FAMILY? YES ☐ NO ☐

HAS A PHYSICIAN TREATED YOU FOR ANY HEALTH CONDITION IN THE LAST YEAR? YES ☐ NO ☐

IF YES, PLEASE DESCRIBE:_____

_____

REMARKS AND ADDITIONAL INFORMATION:_____

_____

_____

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PLEASE CHECK THE FOLLOWING HABITS:

TOBACCO_____ALCHOHOL_____COFFEE_____DRUGS_____OVEREATING_____

PLEASE CHECK THE CONDITIONS YOU NOW HAVE OR HAVE HAD IN THE PAST:

		NECK PAIN			ANEMIA			POLIO
		HEADACHES			NERVOUSNESS			ULCERS
		DIZZINESS			BED WETTING			ARTHRITIS
		ARM PAIN			HEMORRHOIDS			CANCER
		ARM NUMBNESS			HOT FLASHES			CHEST PAIN
		HAND NUMBNESS			CONSTIPATION			DIABETES
		LOW BACKACHES			NOSE BLEEDS			DIARRHEA
		MID BACKACHES			SINUS TROUBLE			GOUT
		LEG PAIN			LUMPS IN BREAST			GOITER
		LEG NUMBNESS			SLEEPING PROBLEMS			ASTHMA
		SCIATICA			LOW BLOOD PRESSURE			COLITIS
		JOINT SWELLING			HIGH BLOOD PRESSURE			ALLERGIES
		NASEA			PAIN BETWEEN SHOULDERS			HEART TROUBLE
		FREQUENT URINATION			DEPRESSION			
		LOSS OF APPETITE			DIFFICULTY SWALLOWING			

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

NAME OF PERSON RESPONSIBLE FOR PAYMENT:_____

ARE YOU INSURED? YES ( ) NO ( ) COMPANY_____

GROUP#_____ID#_____PHONE:_____

ASSIGNMENT AND RELEASE

I UNDERSTAND AND AGREE ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO MY AND ANY HEALTH OR ACCIDENT INSURANCE POLIDIES ARE BETWEEN THE INSURANCE CARRIER AND MYSELF. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES. CHIROPRACTIC CARE CENTER WILL ASSIST IN PREPARING ANY NECESSARY FORMS OR REPORTS AND I AUTHORIAE THE CHIROPRACTOR TO RELEASE ANY INFORMATION REQUIRED.

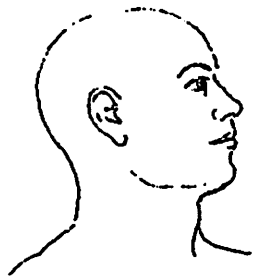
PATIENT'S SIGNATURE:_____DATE:_____

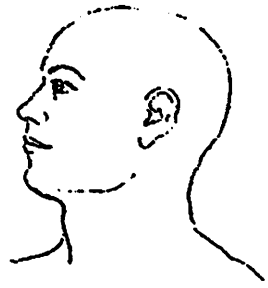
GUARDIANS SIGNATURE:_____DATE:_____

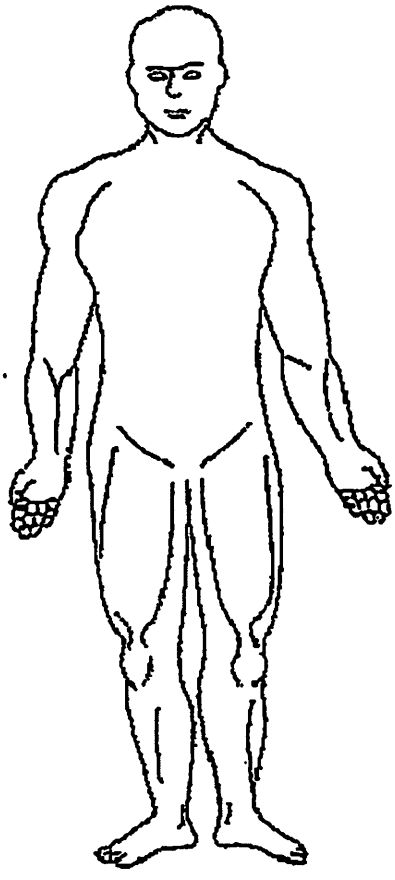
PAIN CHART

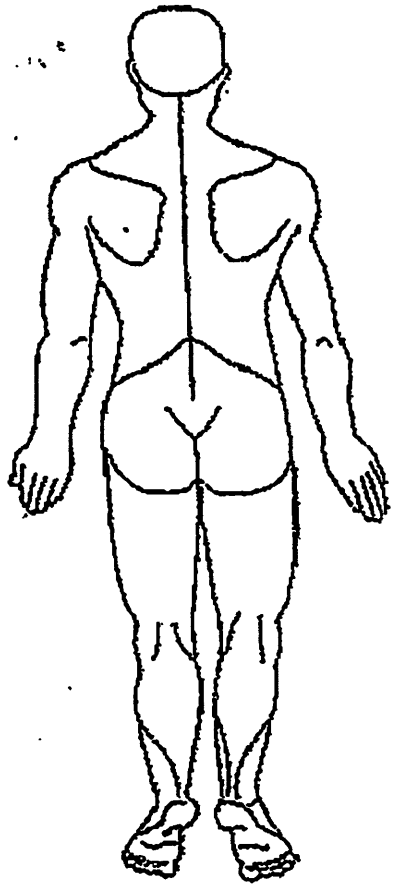
Please make the number on the drawing that most closely describes the sensations you feel.
Use arrows to show radiating pain or odd sensations. Fill this out very accurately.

1. numbness
2. tingling
3. burning
4. ache
5. sharp
6. throbbing
7. stabbing
8. pins and needles









PATIENT SIGNATURE:_____ DATE:_____

FUNCTIONAL RATING INDEX

(FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY)

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 THAT MOST CLOSELY DESCRIBES YOUR CONDITION RIGHT NOW.

1. PAIN INTENSITY

0	1	2	3	4
NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN	WORST POSSIBLE PAIN

2. SLEEPING

0	1	2	3	4
PERFECT SLEEP	MILDLY DISTURBED SLEEP	MODERATELY DISTURBED SLEEP	GREATLY DISTURBED SLEEP	TOTALLY DISTURBED SLEEP

3. 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

4. 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 SHORT TRIPS

5. WORK

0	1	2	3	4
CAN DO USUAL WORK PLUS EXTRA WORK	CAN DO USUAL WORK NO EXTRA WORK	CAN DO 50% OF USUAL WORK	CAN DO 25% OF USUAL WORK	CANNOT WORKUNLIMITED

6. RECREATION

0	1	2	3	4
CAN DO USUAL ALL ACTIVITIES	CAN DO MOST ACTIVITIES	CAN DO SOME ACTIVATES	CAN DO A FEW ACTIVITIES	CANNOT DO ANY ACTIVITIES

7. 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

8. 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

9. 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 ANY WALKING

10. 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

Name_____ Total Score_____

Printed

_____ _____

Signature Date