



General Information

Last Name _____ First Name _____ Date ___/___/___
Address _____ City _____ Zip _____
Home Phone _____ Cell Phone _____
Email _____ Birthday ___/___/___ Sex: M F
Social Security # _____ Drivers License # _____ (State) _____
Marital Status: _____ Spouse's Name _____ Number of Children: _____
Emergency Contact (name) _____ (phone) _____ (relationship) _____
Occupation _____ Employer _____
Employer's Address _____ City/State _____ Zip _____
Work Phone _____
Whom may we thank for referring you to our clinic? _____

Insurance Information

Health Insurance Company _____ Policy # _____ Group # _____
Spouse's Insurance Company _____ Policy # _____ Group # _____
Is your condition due to: Auto Accident Personal Injury Work Injury Other _____

Authorization to release records to patient's insurance carrier.

(Please sign here) _____ Date ___/___/___
(Parent / Legal Guardian) _____ Date ___/___/___

Medications

Please list all medications that you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Family History

Has any member of your family been diagnosed with any of the following: Cancer Diabetes High Blood Pressure Stroke Heart Disease If yes, what is their relation to you? _____

Vascular Screening Symptoms

Have you recently experienced any of the following? (mark all that apply): Dizziness Fainting / Loss of Consciousness A recent decrease in Coordination Trouble Swallowing Nausea Slurred Speech Recent Unexplained Weight Gain or Loss Change in Urination Blurred Vision, Double Vision, or Visual Disturbances (other than those associated with normal aging or corrected with glasses or contacts) None of the above.

If you are experiencing Headaches or Neck Pain, have you experience pain like this before?

Yes, I have had headaches / neck pain like this before.

No, this pain is different than I have experienced in the past.

Is your headache worse in the morning or afternoon?

Do your headaches wake you from your sleep? Yes No

Women Only

Is there any chance that you may be PREGNANT? Yes No

Date of last menstrual period ____/____/____

Cultural Background / Race

Caucasian/White African American Latin American Native American Asian American Other

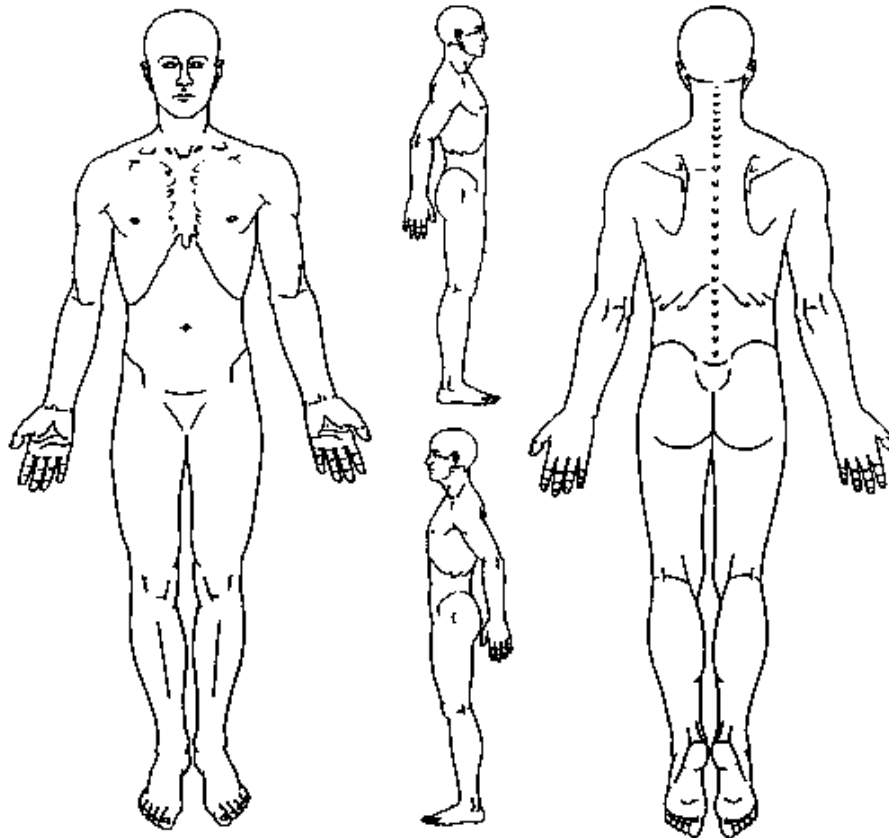
Previous/Current Conditions

Do you currently have or have you ever had any of the following: Asthma Emphysema Tuberculosis Cancer/Tumor Diabetes Epilepsy/Seizures Hyper/Hypo Thyroid High/Low Blood Pressure Heart Disease Pacemaker Stroke Aneurysm Anemia Rheumatic Fever Polio Multiple Sclerosis Ulcer Liver Trouble Kidney Trouble Prostate Trouble Erectile Dysfunction Arthritis Osteoporosis Scoliosis Dislocated Joints Spinal Disc Disease Mental/Emotional Difficulty Sexually Transmitted Disease HIV/AIDS Bone Fractures

(list/date) _____

Other _____

Please shade area(s) of complaint



Please check all that apply:

Spinal: Neck Pain Upper Back Pain Mid Back Pain Low Back Pain Neck Stiffness
 Upper Back Stiffness Mid Back Stiffness Low Back Stiffness

Upper Extremity:

Left

- Shoulder Pain
- Arm Pain
- Elbow Pain
- Forearm Pain
- Wrist Pain
- Hand Pain

Right

- Shoulder Pain
- Arm Pain
- Elbow Pain
- Forearm Pain
- Wrist Pain
- Hand Pain

Lower Extremity:

Left

- Hip Pain
- Thigh Pain
- Knee Pain
- Leg Pain

Right

- Hip Pain
- Thigh Pain
- Knee Pain
- Leg Pain

- Ankle Pain
- Ankle Pain
- Foot Pain
- Foot Pain

Miscellaneous: Headache Jaw Pain Chest Pain Fatigue

Other: _____

Current Condition (continued)

Does your pain travel or radiate to any of the following areas? (check all that apply)

- | | | | |
|-----------------------------------|-----------------------------------|----------------------------------|----------------------------------|
| Left | Right | Left | Right |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Buttock | <input type="checkbox"/> Buttock |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Arm | <input type="checkbox"/> Thigh | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> Forearm | <input type="checkbox"/> Leg | <input type="checkbox"/> Leg |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Hand | <input type="checkbox"/> Foot | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Fingers | <input type="checkbox"/> Fingers | <input type="checkbox"/> Toes | <input type="checkbox"/> Toes |

Are you experiencing any numbness or tingling? (check all that apply)

- | | | | |
|-----------------------------------|-----------------------------------|----------------------------------|----------------------------------|
| Left | Right | Left | Right |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Buttock | <input type="checkbox"/> Buttock |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Arm | <input type="checkbox"/> Thigh | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Forearm | <input type="checkbox"/> Forearm | <input type="checkbox"/> Leg | <input type="checkbox"/> Leg |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Hand | <input type="checkbox"/> Foot | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Fingers | <input type="checkbox"/> Fingers | <input type="checkbox"/> Toes | <input type="checkbox"/> Toes |

Please rate each of your symptoms individually on a scale of 1-10.

0 being no pain at all and 10 being the most pain you have ever had.

- Symptom #1: _____ 0 1 2 3 4 5 6 7 8 9 10
- Symptom #2: _____ 0 1 2 3 4 5 6 7 8 9 10
- Symptom #3: _____ 0 1 2 3 4 5 6 7 8 9 10
- Symptom #4: _____ 0 1 2 3 4 5 6 7 8 9 10
- Symptom #5: _____ 0 1 2 3 4 5 6 7 8 9 10
- Symptom #6: _____ 0 1 2 3 4 5 6 7 8 9 10
- Symptom #7: _____ 0 1 2 3 4 5 6 7 8 9 10

When did your symptoms begin? _____

What was the cause of your symptoms? Auto Accident Work Injury Lifting Slip/Fall Overexertion
 Strenuous Position Unknown Other _____

How soon did the symptoms come on? Immediately Hours Later Next Day Days Later About a Week Later Other _____

Have you experienced symptoms like these before? No Yes (when?) _____

What aggravates your condition? Coughing Sneezing Barring Down Lifting Bending Pushing
 Pulling Sitting Standing Lying Down Walking Moving Your Head Other _____

What alleviates your condition? Rest Movement Sitting Standing Lying Down Bracing Heat
 Ice Massage Stretching "Popping" Aspirin Ibuprofen Tylenol/Acetaminophen Prescribed
Medication Other: _____

How would you characterize your pain? (check all that apply): Dull Sharp Achy Shooting Burning
 Stabbing Throbbing Stiffness Other: _____

What time of the day are your symptoms worse? Morning Afternoon Evening While Sleeping
 At Work Other: _____

What time of the day are your symptoms better? Morning Afternoon Evening While Sleeping At Work
 Other: _____

Are your symptoms getting: Better Worse Staying the Same

When your symptoms are at their worst describe what happens. _____

If these problems continue on without treatment, what do you think would happen? _____

Sleep Habits

Healing occurs when you get restful sleep. Please answer the following questions about your sleep habits:

Do you have trouble falling asleep due to being uncomfortable? Yes No

How long does it take to fall asleep? _____

Is your sleep less restful? Yes No

Do you wake during the night? Yes No

Approximately how many times? _____

Do you wake earlier than you normally would? Yes No

Can you get back to sleep? Yes No

Activities of Daily Living

This next series of questions are about the affect your condition has had on your activities of daily life. We also will use this information to measure your progress and the results of your treatment if we are able to accept you for care.

Work

How do your health problems make it harder to do your job? _____

Are you less productive on your job because of your health problems? Yes No

Do you enjoy work less? Yes No

Do you have to take more breaks? Yes No

Are you concerned about your ability to do your job or the security of your job? Yes No Please

Explain_____

Social

How do your health problems affect your relationships with your family and friends? For example: Are you less fun to be with? Do you help less around the house? Are there things you do less?_____

Recreational Activities

What hobbies or interests do you have outside of work?_____

When your problems are at their worst, do they affect how you do or enjoy your hobby/interest? Yes No
If you didn't have this condition how would it affect how you do your hobbies/interests?_____

Is there anything else you would do more of or just enjoy more if it wasn't for these conditions?_____

Previous Testing

What testing have you had done and when? X-ray: Yes No Area_____ Date_____

MRI: Yes No Area_____ Date_____ CAT Scan: Yes No Area_____

Date_____ Electrodiagnostics (EMG/NCV): Yes No Area_____ Date_____

Was there a previous diagnosis for your condition?_____

Previous Treatment

Have you ever seen anyone else for this condition? Yes No

If Yes, who and when?_____

Have you ever received Physical therapy? Yes No Chiropractic care? Yes No Acupuncture therapy?

Yes No Massage therapy? Yes No Other_____

Have you considered any other treatment? If yes what?_____

What were the results from each type of treatment?_____

Treatment Options

Is there any type of treatment that you would not consider at this time? _____

What is your most important treatment objective?(Reduce pain, increase function, correct cause, prevent progression.)

Would you like a report of the care you receive here sent to you primary care physician? Yes No

If Yes, please provide the following: Physician's Name: _____

Address _____

Previous Accidents/Injuries/Hospitalizations/Surgeries

Do you have a history of any of the following? Work Injury Auto Accident Slip and Fall Accident

If so please list approximate dates and incident:

1. Date ___/___/___ Incident _____

2. Date ___/___/___ Incident _____

3. Date ___/___/___ Incident _____

Have you ever been hospitalized? Yes No If so, when and for what condition?

1. Date ___/___/___ Condition _____

2. Date ___/___/___ Condition _____

3. Date ___/___/___ Condition _____

Have you had any surgeries? Yes No If so, when and for what condition?

1. Date ___/___/___ Surgery _____

2. Date ___/___/___ Surgery _____

3. Date ___/___/___ Surgery _____

Life Style Habits

Smoking (packs per day): Never 1 2 3 4+ Quit _____ years ago.

Caffeinated drinks (glasses per day): 0 1 2 3 4 5 6+

Alcohol consumption (glasses per day): 0 1 2 3 4 5 6+

Drug/Substance use: Yes No

Exercise (times per week): 0 1 2 3 4 5 6 7

Type of exercise _____

Average amount of sleep per night (hours): 0 1 2 3 4 5 6 7 8 9 10 11 12

What do you feel your stress level is currently? (0 being no stress and 10 being maximal stress)

1 2 3 4 5 6 7 8 9 10

Please list vitamin, mineral, and herbal supplements you are currently taking:

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____