PERSONAL INFORMATION

NAME: _____ BIRTH DATE: _____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

CELL PHONE: (_____) _____ -- _____ WORK PHONE: (_____) _____ -- _____

HOME PHONE: (_____) _____ -- _____ E-MAIL: _____

SS #: _____--_____--_____ GENDER: M F REFERRED BY: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SPOUSE/PARTNER NAME: _____

OCCUPATION: _____ EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

EMERGENCY CONTACT INFORMATION

CONTACT NAME: _____ CONTACT PHONE: (_____) _____ -- _____

RELATIONSHIP: _____

IS CONDITION: ☐ JOB RELATED ☐ AUTO ACCIDENT ☐ HOME INJURY ☐ FALL ☐ OTHER: _____

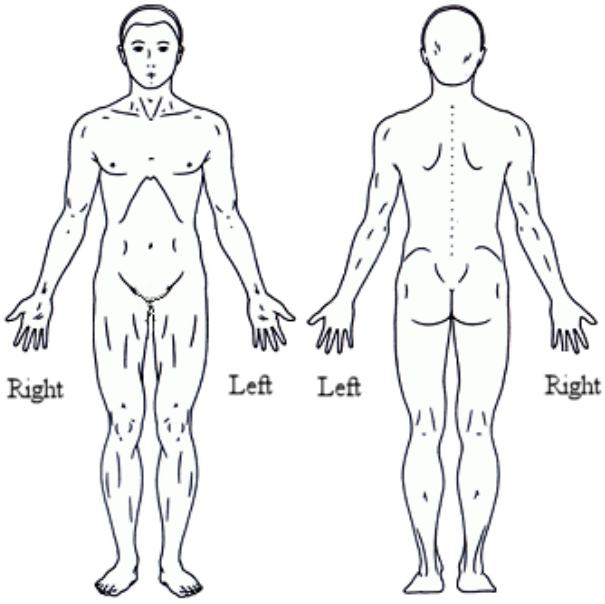
CURRENT HEALTH CONDITION

SPECIFIC PURPOSE OF THIS APPOINTMENT: _____

IF YOU HAVE PAIN, DOES IT TRAVEL OR RADIATE ANYWHERE ELSE IN YOUR BODY? Y N

IF YES, WHERE DOES IT TRAVEL / RADIATE TO? _____

PLEASE MARK YOUR PROBLEM AREAS ON THE DIAGRAM BELOW



HOW INTENSE ARE YOUR SYMPTOMS?

MILD MODERATE SEVERE

HOW WOULD YOU RATE YOUR DISCOMFORT AT ITS WORST?

0 1 2 3 4 5 6 7 8 9 10

NO PAIN *WORST PAIN EVER*

THE PAIN / DISCOMFORT IS:

CONSTANT COMES & GOES

WHEN DID THIS PROBLEM BEGIN?: _____ HOW DID IT START? GRADUALLY SUDDENLY

HAS THIS PROBLEM OCCURRED BEFORE? Y N *IF YES, WHEN?* _____

IF YES, WHAT DID YOU DO AND WHAT WAS THE OUTCOME? _____

DID ANYTHING CONTRIBUTE TO THE ONSET OF YOUR PROBLEM? _____

DOES THIS CONDITION NEGATIVELY AFFECT YOUR:

☐ WORK	☐ STANDING	☐ SELF-CARE	☐ EXERCISE / SPORTS	☐ MOOD
☐ SCHOOL	☐ SITTING	☐ SLEEPING	☐ RELATIONSHIPS	☐ SEXUAL FUNCTION
☐ SOCIAL LIFE	☐ WALKING	☐ LIFTING	☐ CONCENTRATION	☐ OTHER: _____

HOW OFTEN DO YOU EXPERIENCE YOUR PROBLEM (*E.G. DAILY, ONCE PER WEEK, ETC.*)? _____

DOES ANYTHING MAKE YOUR PROBLEM WORSE (*E.G. SITTING, STANDING, BENDING, ETC.*)? _____

_____

DOES ANYTHING MAKE YOUR PROBLEM BETTER? _____

HAVE YOU HAD ANY CHANGES IN BODILY FUNCTIONS (*BOWEL / BLADDER CONTROL, BREATHING, ETC.*)? Y N

IF YES, PLEASE EXPLAIN: _____

ARE YOU CURRENTLY EXPERIENCING ANY MUSCLE WEAKNESS OR NUMBNESS ON ONE SIDE OF YOUR BODY, DIZZINESS, NAUSEA, HEADACHES, DIFFICULTY SPEAKING, DIFFICULTY SWALLOWING OR VISION PROBLEMS? Y N

IF YES, PLEASE CIRCLE SYMPTOMS ABOVE AND EXPLAIN: _____

HAVE YOU SEEN ANY OTHER HEALTHCARE PROFESSIONALS FOR THIS CONDITION? ? Y N

IF YES, WHO AND WHEN? _____

PLEASE LIST ANY OTHER PERSISTENT MEDICAL CONDITIONS YOU SUFFER FROM: _____

_____

_____

_____

_____

PREVIOUS CHIROPRACTIC CARE HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? Y N

IF YES, FOR WHAT PROBLEM: _____ DATE OF LAST VISIT: _____

DOCTOR'S NAME: _____ HOW LONG WERE YOU UNDER CARE? _____

HOW WAS YOUR EXPERIENCE? _____

_____

PAST HEALTH HISTORY

MAJOR INJURIES / TRAUMAS / SURGERIES / HOSPITALIZATIONS: _____

_____

_____

_____

_____

_____

DO YOU HAVE ANY IMPLANTED SURGICAL DEVICES (*E.G. PACEMAKER, SURGICAL CLIPS, I.U.D., RODS / PINS / SCREWS, JOINT REPLACEMENTS, CAGES, HEART VALVES, SHUNT / STENT, JOINT REPLACEMENT, INSULIN PUMPS, ETC.*)? Y N

IF YES, PLEASE DESCRIBE: _____

DO YOU HAVE A HISTORY OF STROKE, HIGH BLOOD PRESSURE, HEART DISEASE, CANCER OR DIABETES? Y N

IF YES, PLEASE CIRCLE ALL THAT APPLY & DESCRIBE TREATMENT AND OUTCOMES: _____

_____

HAVE YOU GAINED OR LOST ANY WEIGHT WITHIN THE LAST 6 MONTHS WITHOUT TRYING? Y N

PLEASE LIST ALL PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS AND / OR SUPPLEMENTS YOU CURRENTLY TAKE & THE REASON FOR TAKING THEM:

_____

_____

_____

_____

SOCIAL HISTORY & HABITS

HOW STRESSFUL IS YOUR JOB / SCHOOL? 0 1 2 3 4 5 6 7 8 9 10

BEST *WORST*

HOW STRESSFUL IS YOUR PERSONAL / HOME LIFE? 0 1 2 3 4 5 6 7 8 9 10

BEST *WORST*

DO YOU SMOKE OR USE ANY TOBACCO PRODUCTS? Y N _____ PER DAY / WEEK

DO YOU CONSUME ALCOHOL? Y N _____ DRINKS PER DAY / WEEK / MONTH

DO YOU CONSUME CAFFEINE? Y N _____ CUPS PER DAY / WEEK

HOW MANY HOURS OF SLEEP DO YOU AVERAGE PER DAY? _____

DO YOU HAVE A REGULAR EXERCISE PROGRAM? Y N

IF YES, WHAT TYPE, HOW OFTEN AND HOW INTENSE? _____

WHAT DO YOU LIKE TO DO FOR RECREATION (*I.E. HOBBIES, SPORTS, ACTIVITIES*) ? _____

_____

NAME: _____ DATE: _____

PLEASE PLACE AN [X] NEXT TO ANY CONDITIONS YOU ARE CURRENTLY SUFFERING FROM AND A [●] NEXT TO ANY CONDITIONS YOU HAVE HAD IN THE PAST.

GENERAL
___ Headaches
___ Migraine Headaches
___ Allergies
___ Sleep Difficulties
___ Jaw Problems
___ Bruise Easily
___ Fatigue
___ Depression
___ Anxiety
___ Mental / Emotional Disorder
___ Eating Disorder
___ Learning Disability
___ Attention Deficit
___ Cancer
___ Diabetes
___ Osteoporosis

MUSCLES & JOINTS
___ Neck Pain
___ Pain Between Shoulders
___ Low Back Pain
___ Joint Pain / Stiffness
___ Arthritis
___ Muscle Tightness
___ Difficulties Walking
___ Carpal Tunnel

NERVOUS SYSTEM
___ Numbness / Tingling
___ Weakness
___ Dizziness
___ Paralysis
___ Fainting
___ Ringing In Ears
___ Convulsions/ Epilepsy
___ Loss of Balance
___ Seizures

GASTROINTESTINAL
___ Belching / Gas
___ Constipation
___ Diarrhea
___ Excessive Hunger / Thirst
___ Poor Appetite
___ Abdominal Pains / Cramps
___ Persistent Nausea
___ Gall Bladder Problems
___ Hemorrhoids
___ Nausea
___ Vomiting
___ Heartburn / Reflux
___ Black / Bloody Stools
___ Loose Stools
___ Gall Bladder Problems
___ Colitis
___ Digestive Problems
___ Loss of Bowel Control

CARDIOVASCULAR
___ Chest Pain
___ Shortness of Breath
___ Blood Pressure Problems
___ Heart Problems
___ Heart Attack
___ Stroke / TIA
___ Irregular Heartbeat
___ Swollen Ankles
___ Varicose Veins

RESPIRATORY
___ Lung Problems
___ Asthma
___ Difficulty Breathing
___ Cough
___ Spitting Blood

GENITOURINARY
___ Frequent Urination
___ Lack of Bladder Control
___ Kidney Problems
___ Painful Urination
___ Discolored Urine
___ Prostate problems

MALE / FEMALE
___ Menstrual Irregularity
___ Menstrual Cramping
___ Vaginal Pain / Infection
___ Breast pain / Lumps
___ Sexual Dysfunction

HEMATOLOGIC / LYMPHATIC
___ Anemia
___ Bleeding
___ Blood Clotting Problems
___ Bruise Easily
___ Lymph Node Swelling
___ Lymph Nodes Removed

FEMALE ONLY
When was your last period? _____
Are you pregnant?
□ YES □ NO □ NOT SURE

I HEREBY CERTIFY THAT ALL ANSWERS AND INFORMATION PROVIDED ON THESE FORMS IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH.

_____ _____ _____
PATIENT SIGNATURE ***PRINTED NAME*** ***DATE***

Functional Rating Index

In order to properly assess your condition, we must understand how much your neck and/or back problems are affecting your ability to manage everyday activities.

For each item below, please circle the **ONE CHOICE** which most closely describes your condition right now.

1. PAIN INTENSITY

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

2. SLEEPING

0	1	2	3	4
PERFECT SLEEP	MILDLY DISTURBED	MODERATELY DISTURBED	SEVERELY DISTURBED	UNABLE TO SLEEP

3. PERSONAL CARE (*ie. washing, dressing, etc.*)

0	1	2	3	4
NO PAIN; NO RESTRICTIONS	MILD PAIN; NO RESTRICTIONS	MODERATE PAIN; GO SLOWLY	MODERATE PAIN; SOME ASSISTANCE	SEVERE PAIN; NEED 100% ASSISTANCE

4. SITTING

0	1	2	3	4
NO PAIN WITH ANY LENGTH OF TIME	INCREASED PAIN AFTER SEVERAL HOURS	INCREASED PAIN AFTER 1 HOUR	INCREASED PAIN AFTER ½ HOUR	INCREASED PAIN AFTER ANY TIME

5. WORK – *I CAN PERFORM*

0	1	2	3	4
USUAL WORK + EXTRA WORK (*IF NEEDED*)	USUAL WORK; NO EXTRA WORK	50% OF USUAL WORK	25% OF USUAL WORK	UNABLE TO WORK

6. RECREATION – *I CAN PERFORM*

0	1	2	3	4
ALL ACTIVITIES	MOST ACTIVITIES	SOME ACTIVITIES	FEW ACTIVITIES	NO ACTIVITIES

7. FREQUENCY OF PAIN

0	1	2	3	4
NO PAIN	OCCASIONAL (25% OF TIME)	INTERMITTENT (50% OF TIME)	FREQUENT (75% OF TIME)	CONSTANT (100% OF TIME)

8. LIFTING

0	1	2	3	4
NO PAIN	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 WITH ANY DISTANCE	INCREASED PAIN AFTER 1 MILE	INCREASED PAIN AFTER ½ MILE	INCREASED PAIN AFTER ¼ MILE	INCREASED PAIN WITH ANY DISTANCE

10. STANDING

0	1	2	3	4
NO PAIN WITH ANY LENGTH OF TIME	INCREASED PAIN AFTER SEVERAL HOURS	INCREASED PAIN AFTER 1 HOUR	INCREASED PAIN AFTER ½ HOUR	INCREASED PAIN AFTER ANY TIME

_____ _____ _____

PATIENT SIGNATURE ***PRINTED NAME*** ***DATE***