

PATIENT INFORMATION

Patient Name (First) (Middle) (Last)				
Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status	Today's Date	Referring Physician
SS#	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both -handed		Phone	Fax
Patient Address			Patient Employer Name	
City/State/ZIP			Address	
Phone- home	work	cell	City/State/ZIP	Phone
Responsible Party			Family Physician	
Address			Address	
City/State/ZIP			City/State/ZIP	
Phone			Phone	
Responsible Party SS#			Emergency Contact	Phone

INSURANCE INFORMATION

PRIMARY INSURANCE (TO BE BILLED FIRST). MUST BE COMPLETED TO BILL INSURANCE

Name of Insurance Company		Group/Claim Number		Copay Amount
Insurance Company Address		City	State	ZIP Phone
Card Numbers	Policy Holder Birthdate	Policy Holder Name		SS#

SECONDARY INSURANCE

Name of Insurance Company		Group/Claim Number		
Insurance Company Address		City	State	ZIP Phone
Card Numbers	Policy Holder Birthdate	Policy Holder Name		SS#

WORK OR AUTO ACCIDENT

Is this visit due to a work or auto accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of loss or injury		
Carrier/Insured Name		Claim Number		
Address		City	State	ZIP Phone
Adjustor Name			Phone	Fax

QUESTIONS TO ASK MY DOCTOR

Because your health is a priority to us, we want to make sure you get the most out of your appointment by feeling as informed as possible. So that we can address your specific concerns, please take a few moments to jot down any questions you have regarding your condition or care.

PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name (First)		(Middle)	(Last)
Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Today's Date

CHIEF COMPLAINT Describe briefly the main problem for which you are here today. How long have you had this problem? Is your condition related to an injury? Yes <input type="checkbox"/> No <input type="checkbox"/>	BLEEDING Do you bleed excessively? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you bruise easily? Yes <input type="checkbox"/> No <input type="checkbox"/> Bleeding disorders in family members? Yes <input type="checkbox"/> No <input type="checkbox"/> CORTISONE/PREDNISONE Have you had cortisone/prednisone by mouth in the last 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/>
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PAST MEDICAL HISTORY Serious Injuries: <i>(describe any significant injuries you have had in your life)</i> _____ year _____ _____ year _____ _____ year _____ _____ year _____ Surgeries: <i>(List any previous operations you have had)</i> _____ year _____ _____ year _____ _____ year _____ _____ year _____ Have you ever had a problem with anesthesia? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, explain: _____ Medical Conditions: <i>(Describe any other illnesses you have had, such as diabetes, high blood pressure, heart disease, etc.)</i> _____ _____ _____ Do you have a history of cancer? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, which type? _____	MEDICATIONS LIST Medication Name _____ Dosage _____ Times per day _____ Reasons for Prescription _____ Medication Name _____ Dosage _____ Times per day _____ Reasons for Prescription _____ Medication Name _____ Dosage _____ Times per day _____ Reasons for Prescription _____ Medication Name _____ Dosage _____ Times per day _____ Reasons for Prescription _____ Medication Name _____ Dosage _____ Times per day _____ Reasons for Prescription _____ Medication Name _____ Dosage _____ Times per day _____ Reasons for Prescription _____
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ALLERGIES Do you have any allergies to Medications? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, please list and describe reaction</i> Do you have allergies to other substances? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If yes, please list</i> Are you allergic to latex? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you allergic to X-ray/contrast dye? Yes <input type="checkbox"/> No <input type="checkbox"/>
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PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name (First)	(Middle)	(Last)
Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Today's Date

TELL US ABOUT YOUR SYMPTOMS

Is the pain mostly in the back, neck or elsewhere _____

How long ago did these symptoms begin? _____

How did they begin? _____

Is the pain constant, or does it come and go? _____

How do these symptoms limit you? _____

What things make the pain better? _____

What makes the pain worse? _____

Do you have pain that radiates into the arm or leg? Yes No

Have you lost control of your bowel/bladder functions Yes No

Do you have any weakness or numbing/tingling in an arm or leg? Yes No

How many minutes can you: Sit _____ Stand _____ Walk _____

Is your pain a result of: Fall Auto Accident

Injury on the job? Yes No or other _____

Have you ever had back/neck problems before this injury? Yes No

Employer at the time of injury:

Does your job require lifting, standing, or bending?

Is there a lawsuit pending on this problem? Yes No

Who treated you first for this problem?

Have you seen a chiropractor? Yes No

What treatments did you have then? _____

What tests have you had? _____

Did you have any injections for your problem? Yes No
Where? _____

Did these injections help? Yes No

Did you have previous back or neck surgery? Yes No
Where? _____

Have you had physical therapy for this problem? Yes No







Did this therapy help? Yes No

Do you do any special exercises for your back or neck? Yes No

What medications have you tried in the past?

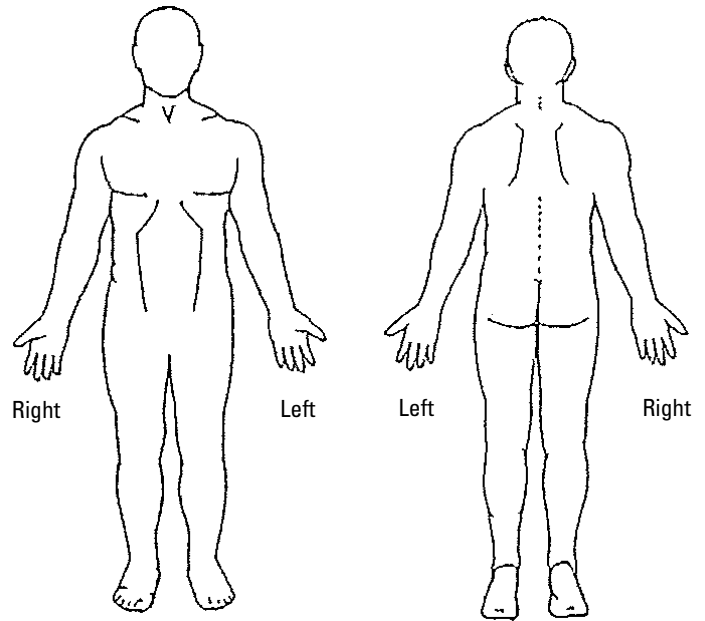
What other concerns do you have?

Circle your pain level: 0 to 10, 10 being the worst imaginable pain.

										
0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild, Annoying	Nagging, Uncomfortable, Troublesome	Miserable, Distressing	Intense, Dreadful, Horrible	Worst Pain Possible					
	<small>Pain is present but does not limit activity</small>	<small>Can do most activities with rest periods</small>	<small>Unable to do some activities because of pain</small>	<small>Unable to do most activities because of pain</small>	<small>Unable to do most activities because of pain</small>					

Draw your pain on the diagrams shown. Use the symbols below to show the type of pain you feel.

- | | |
|----------------|-----|
| Stabbing pain | /// |
| Burning pain | ooo |
| Aching pain | xxx |
| Pins & Needles | yyy |
| Numbness | === |



Front

Back

PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name (First)	(Middle)	(Last)
Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Today's Date

Do you have any of the following symptoms? If "yes", please explain. Use additional space at the end of this section if needed.

GENERAL	STOMACH (GASTROINTESTINAL)
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Unexplained fever/chills: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Night sweats: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Excessive fatigue: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Sleeping problems: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Weight gain/loss: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____	Heartburn/indigestion: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Nausea/vomiting: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Vomiting blood: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Change in bowel habits: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Change in stool color: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Hemorrhoids: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Rectal bleeding: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Colon polyps: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Blood in stool: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Jaundice/hepatitis: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Ulcers: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Recurrent Abdominal pain: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____
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EAR/NOSE/THROAT (ENT)	KIDNEYS (GYNECOLOGIC/URINARY)
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Hearing loss: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Ringing in ears: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Drainage from ears/nose: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Sores in mouth: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Difficulty swallowing: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____	Lower back pain: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Flank/side pain: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Burning with urination: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Urinary urgency/frequency: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Kidney/bladder infections: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Blood in urine: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Passage of kidney stones: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Decreased urine stream: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Hesitancy/dribbling with urination: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Stress incontinence: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____
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EYES	MUSCLES/JOINTS
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Eye pain: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Glaucoma: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Visual loss: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____	Swollen/inflamed joints: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ History of gout: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Artificial joints: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Deformed joints: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Severe arthritis: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____
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HEART (CARDIOVASCULAR)	SKIN
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Heart disease: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ High blood pressure: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Low blood pressure: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Elevated cholesterol: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Chest pain/angina: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Heart racing/skipping: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Heart attack/failure: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Heart murmur: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Rheumatic fever: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Artificial heart valve: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Pacemaker: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Ankle swelling: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____	Changes in moles: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Skin problems: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____
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LUNGS (PULMONARY)	PSYCHIATRIC
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Shortness of breath: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Emphysema: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Recurrent bronchitis: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Chronic cough: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Coughing up blood: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Tuberculosis (TB): Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Positive TB skin test: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ History of pneumonia: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Wheezing: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Asthma: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____	Psychiatric problems: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____ Suicidal thoughts: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: _____
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PATIENT HEALTH HISTORY AND ASSESSMENT

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GLANDS/HORMONES (ENDOCRINE)

Heat/cold tolerance: Yes No Explain: _____

Excessive urination: Yes No Explain: _____

Changes in facial/body hair: Yes No Explain: _____

Increase in hat/glove size: Yes No Explain: _____

Thyroid problems: Yes No Explain: _____

Diabetes: Yes No Explain: _____

HEAD/BRAIN (NEUROLOGIC)

Headache: Yes No Explain: _____

Fainting: Yes No Explain: _____

Seizures/epilepsy: Yes No Explain: _____

Memory loss: Yes No Explain: _____

Speech difficulty: Yes No Explain: _____

Loss of smell: Yes No Explain: _____

Facial numbness/weakness: Yes No Explain: _____

Extremity numbness/weakness: Yes No Explain: _____

Muscle shrinkage: Yes No Explain: _____

Muscle cramping/twitching: Yes No Explain: _____

Dizziness/vertigo: Yes No Explain: _____

Imbalance: Yes No Explain: _____

In-coordination: Yes No Explain: _____

Tremors/Shaking: Yes No Explain: _____

BLOOD (HEMATOLOGIC)

Anemia: Yes No Explain: _____

Enlarged lymph nodes: Yes No Explain: _____

Abnormal blood cells: Yes No Explain: _____

Blood transfusions: Yes No Explain: _____

Transfusion reactions: Yes No Explain: _____

VEINS (VASCULAR)

Leg pain with walking/rest: Yes No Explain: _____

Blood clots in legs: Yes No Explain: _____

Aortic aneurysm: Yes No Explain: _____

Chronic leg ulcers: Yes No Explain: _____

Varicose veins: Yes No Explain: _____

SOCIAL HISTORY

Single Married Divorced Separated Widowed

Do you live alone? Yes No

Employed? Yes No

If yes, occupation _____

If no, is it because of a back or neck problem? Yes No

Date last worked _____

Do you have children? Yes No

How often do you exercise? Never Rarely Weekly Daily

What type of exercise? _____

Have you ever smoked/chewed tobacco? Yes No

If yes, how recently? _____/how much? _____ pack(s) per day

How long have you smoked/chewed? _____

Have you recently stopped? Yes No

If yes, when? _____

Do you drink alcohol? Yes No

If yes, how much? _____

Have you ever been tested for HIV(AIDS)? Yes No

If yes, what was the result? Positive Negative

Do you have a history of substance abuse? Yes No

If yes, what was the substance? _____

FAMILY HISTORY

Do any of your grandparents, parents, siblings or children have any of the following diseases? Explain.

Diabetes: Yes No Explain: _____

High blood pressure: Yes No Explain: _____

Heart attack: Yes No Explain: _____

Cancer: Yes No Explain: _____

Arthritis: Yes No Explain: _____

Rheumatoid Arthritis: Yes No Explain: _____

Back or neck problems: Yes No Explain: _____

AIDS/HIV: Yes No Explain: _____

Bleeding disorders: Yes No Explain: _____

Epilepsy: Yes No Explain: _____

Hepatitis: Yes No Explain: _____

Migraines/headaches: Yes No Explain: _____

Psychiatric problems: Yes No Explain: _____

Stomach: Yes No Explain: _____

Thyroid problems: Yes No Explain: _____

I hereby authorize this facility to examine and treat me or my dependent child and to perform such diagnostic tests and/or x-rays as may be necessary for the duration of treatment for this injury or illness. I hereby authorize the release of any medical information necessary to process my Medicare and/or insurance claims and for any benefits payable under my policy to be paid directly to this facility. I understand this information may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental health disorders and/or HIV serostatus. I understand that I am responsible for payment of any charges incurred. I accept this responsibility regardless of any reimbursement or coverage. In the case of Medicare, I am responsible for payment of any charges not paid by Medicare.

Patient Signature _____ Date _____

Reviewed by _____ Date _____