PATIENT INFORMATION

Patient Name (First)	(Middle)	(Last)			
Birth Date	Sex ☐ M ☐ F	Marital Status	Today's Date	Referring Physician	
SS#	☐ Right ☐ Left ☐ 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 ☐ No ☐		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 ☐ M ☐ 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 ☐ No ☐

PAST MEDICAL HISTORY

Serious Injuries: *(describe any significant injuries you have had in your life)*

_____ *year* _____
_____ *year* _____
_____ *year* _____
_____ *year* _____

Surgeries: *(List any previous operations you have had)*

_____ *year* _____
_____ *year* _____
_____ *year* _____
_____ *year* _____

Have you ever had a problem with anesthesia? Yes ☐ No ☐

If yes, explain: _____

Medical Conditions: *(Describe any other illnesses you have had, such as diabetes, high blood pressure, heart disease, etc.)*

_____
_____
_____
_____

Do you have a history of cancer? Yes ☐ No ☐

If yes, which type? _____

ALLERGIES

Do you have any allergies to Medications? Yes ☐ No ☐

If yes, please list and describe reaction

Do you have allergies to other substances? Yes ☐ No ☐

If yes, please list

Are you allergic to latex? Yes ☐ No ☐

Are you allergic to X-ray/contrast dye? Yes ☐ No ☐

BLEEDING

Do you bleed excessively? Yes ☐ No ☐

Do you bruise easily? Yes ☐ No ☐

Bleeding disorders in family members? Yes ☐ No ☐

CORTISONE/PREDNISONE

Have you had cortisone/prednisone by mouth in the last 12 months? Yes ☐ No ☐

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 _____

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Reasons for Prescription _____

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Dosage _____
Times per day _____
Reasons for Prescription _____

Medication Name _____
Dosage _____
Times per day _____
Reasons for Prescription _____

PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name (First)	(Middle)	(Last)
Birth Date	Sex ☐ M ☐ 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 Yes ☐ No ☐
in an arm or leg?_____

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?

_____

_____

_____

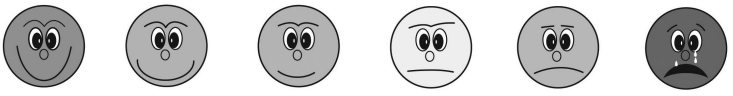
What other concerns do you have?

_____

_____

_____

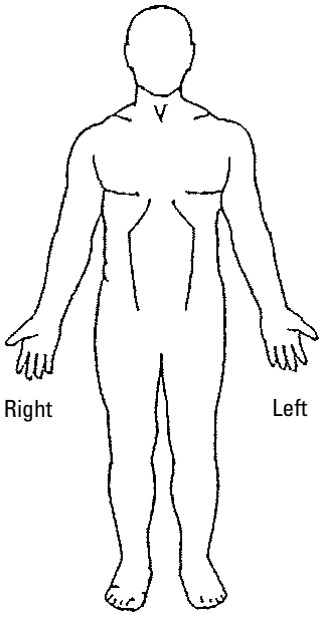
Circle your pain level: 0 to 10, 10 being the worst imaginable pain.



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

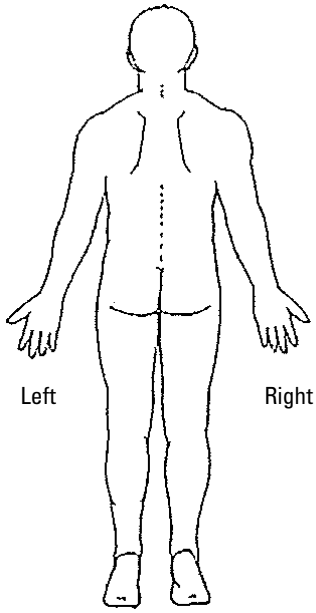
Draw your pain on the diagrams shown. Use the symbols below to show the type of pain you feel.

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



Right Left

Front



Left Right

Back

PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name (First)	(Middle)	(Last)
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Do you have any of the following symptoms? If "yes", please explain. Use additional space at the end of this section if needed.

GENERAL

Unexplained fever/chills: Yes ☐ No ☐ Explain: _____
Night sweats: Yes ☐ No ☐ Explain: _____
Excessive fatigue: Yes ☐ No ☐ Explain: _____
Sleeping problems: Yes ☐ No ☐ Explain: _____
Weight gain/loss: Yes ☐ No ☐ Explain: _____

EAR/NOSE/THROAT (ENT)

Hearing loss: Yes ☐ No ☐ Explain: _____
Ringing in ears: Yes ☐ No ☐ Explain: _____
Drainage from ears/nose: Yes ☐ No ☐ Explain: _____
Sores in mouth: Yes ☐ No ☐ Explain: _____
Difficulty swallowing: Yes ☐ No ☐ Explain: _____

EYES

Eye pain: Yes ☐ No ☐ Explain: _____
Glaucoma: Yes ☐ No ☐ Explain: _____
Visual loss: Yes ☐ No ☐ Explain: _____

HEART (CARDIOVASCULAR)

Heart disease: Yes ☐ No ☐ Explain: _____
High blood pressure: Yes ☐ No ☐ Explain: _____
Low blood pressure: Yes ☐ No ☐ Explain: _____
Elevated cholesterol: Yes ☐ No ☐ Explain: _____
Chest pain/angina: Yes ☐ No ☐ Explain: _____
Heart racing/skipping: Yes ☐ No ☐ Explain: _____
Heart attack/failure: Yes ☐ No ☐ Explain: _____
Heart murmur: Yes ☐ No ☐ Explain: _____
Rheumatic fever: Yes ☐ No ☐ Explain: _____
Artificial heart valve: Yes ☐ No ☐ Explain: _____
Pacemaker: Yes ☐ No ☐ Explain: _____
Ankle swelling: Yes ☐ No ☐ Explain: _____

LUNGS (PULMONARY)

Shortness of breath: Yes ☐ No ☐ Explain: _____
Emphysema: Yes ☐ No ☐ Explain: _____
Recurrent bronchitis: Yes ☐ No ☐ Explain: _____
Chronic cough: Yes ☐ No ☐ Explain: _____
Coughing up blood: Yes ☐ No ☐ Explain: _____
Tuberculosis (TB): Yes ☐ No ☐ Explain: _____
Positive TB skin test: Yes ☐ No ☐ Explain: _____
History of pneumonia: Yes ☐ No ☐ Explain: _____
Wheezing: Yes ☐ No ☐ Explain: _____
Asthma: Yes ☐ No ☐ Explain: _____

STOMACH (GASTROINTESTINAL)

Heartburn/indigestion: Yes ☐ No ☐ Explain: _____
Nausea/vomiting: Yes ☐ No ☐ Explain: _____
Vomiting blood: Yes ☐ No ☐ Explain: _____
Change in bowel habits: Yes ☐ No ☐ Explain: _____
Change in stool color: Yes ☐ No ☐ Explain: _____
Hemorrhoids: Yes ☐ No ☐ Explain: _____
Rectal bleeding: Yes ☐ No ☐ Explain: _____
Colon polyps: Yes ☐ No ☐ Explain: _____
Blood in stool: Yes ☐ No ☐ Explain: _____
Jaundice/hepatitis: Yes ☐ No ☐ Explain: _____
Ulcers: Yes ☐ No ☐ Explain: _____
Recurrent Abdominal pain: Yes ☐ No ☐ Explain: _____

KIDNEYS (GYNECOLOGIC/URINARY)

Lower back pain: Yes ☐ No ☐ Explain: _____
Flank/side pain: Yes ☐ No ☐ Explain: _____
Burning with urination: Yes ☐ No ☐ Explain: _____
Urinary urgency/ frequency: Yes ☐ No ☐ Explain: _____
Kidney/bladder infections: Yes ☐ No ☐ Explain: _____
Blood in urine: Yes ☐ No ☐ Explain: _____
Passage of kidney stones: Yes ☐ No ☐ Explain: _____
Decreased urine stream: Yes ☐ No ☐ Explain: _____
Hesitancy/dribbling with urination Yes ☐ No ☐ Explain: _____
Stress incontinence: Yes ☐ No ☐ Explain: _____

MUSCLES/JOINTS

Swollen/inflamed joints: Yes ☐ No ☐ Explain: _____
History of gout: Yes ☐ No ☐ Explain: _____
Artificial joints: Yes ☐ No ☐ Explain: _____
Deformed joints: Yes ☐ No ☐ Explain: _____
Severe arthritis: Yes ☐ No ☐ Explain: _____

SKIN

Changes in moles: Yes ☐ No ☐ Explain: _____
Skin problems: Yes ☐ No ☐ Explain: _____

PSYCHIATRIC

Psychiatric problems: Yes ☐ No ☐ Explain: _____
Suicidal thoughts: Yes ☐ No ☐ Explain: _____

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** _____