

# WELCOME

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  Male  Female

Birth Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated

Name of wife or husband: \_\_\_\_\_ Their occupation: \_\_\_\_\_

How many children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Patient's Nearest Relative: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Parent (if minor): \_\_\_\_\_

Who can we thank for referring us to you: \_\_\_\_\_

If we need to contact you, may we leave a message at the phone numbers you provided?

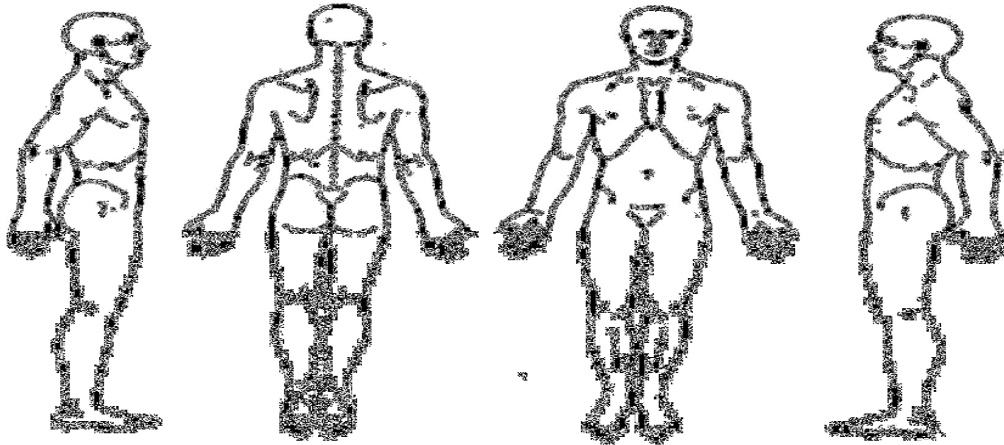
\_\_\_\_\_

**Thank You**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Work Injury

2. Indicate on the drawings below where you have pain/symptoms



Chief complaint or symptom: \_\_\_\_\_

Other complaint(s) or symptom(s): \_\_\_\_\_

3. How often do you experience your symptoms?

- Chief:  Constantly (76-100% of the time)  
 Frequently (51-75% of the time)  
 Occasionally (26-50% of the time)  
 Intermittently (1-25% of the time)

- Other:  Constantly (76-100% of the time)  
 Frequently (51-75% of the time)  
 Occasionally (26-50% of the time)  
 Intermittently (1-25% of the time)

4. How would you describe the type of pain?

Chief Complaint:

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

Other complaint:

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                    |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                  |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion       |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion    |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion    |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like w/ motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____            |

5. How are your symptoms changing with time?

- |        |  |   |   |
|--------|--|---|---|
| Chief: | <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Staying the Same | <input type="checkbox"/> Getting Better |
| Other: | <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Staying the Same | <input type="checkbox"/> Getting Better |

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Chief: 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

Other: 0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

8. How much has the problem interfered with your social activities?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

**9. Who else have you seen for your problem?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chiropractor      | <input type="checkbox"/> Neurologist        | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician      | <input type="checkbox"/> Orthopedist        | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one                 |

Date Treated \_\_\_\_\_

**10. How long have you had this problem?** \_\_\_\_\_

**11. How do you think your problem began?**

\_\_\_\_\_

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**12. Do you consider this problem to be severe?**

- Yes       Yes, at times       No

**13. What aggravates your problem?**

\_\_\_\_\_

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**14. What alleviates your problem?**

\_\_\_\_\_

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**15. What concerns you the most about your problem; what does it prevent you from doing?**

\_\_\_\_\_

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**16. What is your:** Height \_\_\_\_\_      Weight \_\_\_\_\_      Age \_\_\_\_\_

**17. How would you rate your overall Health?**

- Excellent       Very Good       Good       Fair       Poor

**18. What type of exercise do you do?**

- Strenuous       Moderate       Light       None

**19. Indicate if you have any immediate family members with any of the following:**

- |   |                                   |                                |
|---|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Cancer   | <input type="checkbox"/> ALS   |

**20. List all prescription medications you are currently taking:**

\_\_\_\_\_

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**21. List all of the over-the-counter medications and supplements you are currently taking:**

\_\_\_\_\_

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**22. List all surgical procedures you have had:**

\_\_\_\_\_

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**23. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<b>For Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replace
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Cancer		
<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Tumor		
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Asthma		
<input type="checkbox"/>	<input type="checkbox"/> Muscular- Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis		
		<input type="checkbox"/>	<input type="checkbox"/> Other _____		

**24. What activities do you do at work?**

<input type="checkbox"/> <b>Sit:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Stand:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Computer work:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>On the phone:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> <b>Drive:</b>	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Reads a lot	<input type="checkbox"/> Travels frequently	<input type="checkbox"/> Performs manual labor	

**25. What activities do you do outside of work?**

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**26. Have you ever been hospitalized?**     No     Yes

If yes, why

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**27. Have you had significant past trauma?**     No     Yes

If yes, describe \_\_\_\_\_

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**28. Are you pregnant?** \_\_\_\_\_

**29. Anything else pertinent to your visit today?**

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Habits:

Sleep (hours) \_\_\_\_\_  Coffee  Tea  Alcohol  Tobacco  Exercise  Hobbies

Vaccinations and Injections:

Smallpox  Spinal tap or injection  Mumps  Swine-Flu  D.P.T.  Polio

How payment will be made: \_\_\_\_\_ Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card  
\_\_\_\_\_ Work Comp Ins \_\_\_\_\_ Auto Ins \_\_\_\_\_ Health Ins

**I (We) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.**

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Or Guardian's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the Doctor.**

**CONSENT TO CARE**

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

Do Not Write Below This Line

\_\_\_\_\_ Temporary Relief  
\_\_\_\_\_ Health Maintenance

\_\_\_\_\_ Correction and Maintenance  
\_\_\_\_\_ Health Development

**Patient Accepted:**  **Yes**  **No**

\_\_\_\_\_  
Doctor's Signature