Welcome To Our Office!

PATIENT INFORMATION: Today's Date:_____

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Social Security #: _____ Age: _____ ☐ Male ☐ Female

Marital Status: ☐Single ☐Married ☐Divorced ☐ Separated ☐Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation: _____ Your Employer: _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Friend/family member - Name? _____

☐ Clinic Location

☐ Online

- OGoogle
- OFacebook
- OAds

☐ Other _____

INSURANCE:

Name of Insurance Company: _____

Insured's Name: _____

Are you covered by more than one insurance company?

☐ Yes ☐No Name: _____

PAYMENT:

Payment for services will be by: ☐Cash ☐Check ☐Credit Card ☐Health Insurance

Welcome To Our Office!

PATIENT INFORMATION: Today's Date:_____

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Social Security #: _____ Age: _____ ☐ Male ☐ Female

Marital Status: ☐Single ☐Married ☐Divorced ☐ Separated ☐Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation: _____ Your Employer: _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Friend/family member - Name? _____

☐ Clinic Location

☐ Online

- OGoogle
- OFacebook
- OAds

☐ Other _____

INSURANCE:

Name of Insurance Company: _____

Insured's Name: _____

Are you covered by more than one insurance company?

☐ Yes ☐No Name: _____

PAYMENT:

Payment for services will be by: ☐Cash ☐Check ☐Credit Card ☐Health Insurance

WELCOME TO OUR OFFICE!

If you need assistance completing this form, please ask the front desk

Patient Name: _____ Date: _____

FAMILY/MEDICAL HISTORY

S= SELF **M=** MOTHER **F=** FATHER

(Please indicate which conditions have been experienced by marking the boxes:

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	Dislocated Joints	☐	☐	☐	Neck Pain
☐	☐	☐	Anemia	☐	☐	☐	Epilepsy	☐	☐	☐	Nervousness
☐	☐	☐	Arthritis	☐	☐	☐	German Measles	☐	☐	☐	Numbness
☐	☐	☐	Asthma	☐	☐	☐	Headaches	☐	☐	☐	Polio
☐	☐	☐	Back Pain	☐	☐	☐	Heart Trouble	☐	☐	☐	Poor Circulation
☐	☐	☐	Bladder Trouble	☐	☐	☐	Reproductive Disorders	☐	☐	☐	Hepatitis
☐	☐	☐	Bone Fracture	☐	☐	☐	High Blood Pressure	☐	☐	☐	HIV
☐	☐	☐	Cancer	☐	☐	☐	Rheumatic Fever	☐	☐	☐	Rheumatism
☐	☐	☐	Chest Pain	☐	☐	☐	Venereal Disease	☐	☐	☐	Scarlet Fever
☐	☐	☐	Concussion	☐	☐	☐	Loss of Bowel Control	☐	☐	☐	Serious Injury
☐	☐	☐	Convulsions	☐	☐	☐	Menstrual Cramps	☐	☐	☐	Sinus Issues
☐	☐	☐	Diabetes	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	Tuberculosis
☐	☐	☐	Indigestion	☐	☐	☐	Muscular Dystrophy	☐	☐	☐	Kidney Disorder

Have you been treated by a physician for any health condition in the last year? ☐Yes ☐No

Describe Condition: _____ Date of Last Physical Exam: _____

Primary Physician's Name: _____ Phone: _____

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you ever had a metal implant? ☐ Yes ☐ No Any other implants? ☐ Yes ☐ No

Are you allergic to any medications? _____

Are you taking any medications? _____

Are you pregnant? _____ Date of last menstrual period: _____

ACCIDENT HISTORY:

1. _____ ☐ Job ☐ Auto ☐ Other Date:_____
2. _____ ☐ Job ☐ Auto ☐ Other Date:_____

(Over please)

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Rate your symptoms 1-10, with 1 being the least serious

1. _____ ____

2. _____ ____

3. _____ ____

Symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night

How did this injury occur? _____

Was this an accident? (job related, auto, etc.) ☐ Yes ☐ No

How long have you been experiencing symptoms? _____

Check the following activities that **aggravate** your condition:

☐ Bending ☐ Reaching ☐ Sitting ☐ Turning Head ☐ Standing ☐ Lying down

☐ Walking ☐ Lifting ☐ Lifting ☐ Sneezing ☐ Straining passing stool

Check the following activities that **relieve** your condition:

☐ Bending ☐ Sitting ☐ Lifting ☐ Standing ☐ Lying down ☐ Reaching

☐ Turning head ☐ Walking

Please check any **additional** symptoms you are experiencing:

☐ Blurred vision ☐ Buzzing in ears ☐ Cold feet ☐ Cold hands ☐ Cold sweats
☐ Confusion ☐ Concentration loss ☐ Constipation ☐ Diarrhea ☐ Fatigue ☐ Fever
☐ Dizziness ☐ Fainting ☐ Depression ☐ Face flushed ☐ Head seems too heavy
☐ Headaches ☐ Eyes sensitive to light ☐ Insomnia ☐ Loss of balance ☐ Muscle jerking
☐ Loss of smell ☐ Loss of taste ☐ Numbness in fingers ☐ Numbness in toes
☐ Pins and needles in arms ☐ Pins and needles in legs ☐ Stiff neck ☐ Ringing in ears
☐ Shortness of breath ☐ Stomach upset

Please fill out these questions regarding your pain and how it is affecting you. Answer ALL of the scales, marking the number that best describes how you are feeling.

Use the following section to describe any pain, discomfort, or symptoms you are currently experiencing in your **neck**.

1. Over the past week, on average, how would you rate your neck pain?

No Pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, driving, lifting, dressing, reading, etc.)?

No Interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to partake in recreational, social, and family activities?

No Interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (sad, lonely, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

(Over please)

6. Over the past week, how have you felt your work (both inside and outside the home) has affected your neck pain?

Has not made it worse — Has made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce or help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Use the following section to describe any pain, discomfort, or symptoms you are currently experiencing in your **back**.

8. Over the past week, on average, how would you rate your back pain?

No Pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

9. Over the past week, how much has your back pain interfered with your daily activities (housework, driving, lifting, dressing,walking, climbing stairs, getting in/out of bed, etc.)?

No Interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

10. Over the past week, how much has your back pain interfered with your ability to partake in recreational, social, and family activities?

No Interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

11. Over the past week, how have you felt your work (both inside and outside the home) has affected your back pain?

Has not made it worse — Has made it much worse

0 1 2 3 4 5 6 7 8 9 10

12. Over the past week, how much have you been able to control (reduce or help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Thinking about the **past 2 weeks**, circle your response to each of the following statements:

1. My back pain has spread **down my legs** in the past 2 weeks **Agree** **Disagree**
2. I have had pain in my **shoulder** or **neck** in the past 2 weeks **Agree** **Disagree**
3. I have only walked short distances because of my pain **Agree** **Disagree**
4. In the past 2 weeks, I have dressed more slowly because of pain **Agree** **Disagree**
5. I don't feel it's safe for me to be physically active right now **Agree** **Disagree**
6. In general, I have not enjoyed the things I used to recently **Agree** **Disagree**

Overall, how bothersome has your pain been the past 2 weeks?

Not At All ☐ Slightly ☐ Moderately ☐ Very Much ☐ Extremely ☐

Check each box that you feel accurately describes your condition and its limitations: (Answer based on how you feel in this moment)

Pain Intensity

☐ I have no pain ☐ Mild pain ☐ Moderate pain ☐ Fairly severe ☐ Worst pain imaginable

Personal Care

☐ I can look aftermyself normally, but with pain
☐ I can cautiously look after myself, but with pain
☐ I need some help but manage most of my personal care
☐ I need help every day, in most aspects of my personal care
☐ I do not get dressed, wash with difficulty, and stay in bed

(Over please)

Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights, but with pain
- ☐ Pain prevents me from lifting heavy things off the floor, but I can lift them off of tables, etc. when convenient
- ☐ Pain prevents me from listing heavy weights but I can lift light to medium weights when convenient
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything at all

Walking

- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from waking more than a mile
- ☐ Pain prevents me from walking more than ¼ of a mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a cane or crutches
- ☐ I am in bed most of the time

Sitting

- ☐ I can sit in any chair for as long as I like
- ☐ Pain prevents me from sitting for more than 1 hour
- ☐ Pain prevents me from sitting for more than ½ hour
- ☐ Pain prevents me from sitting for more than 10 minutes
- ☐ Pain prevents me from sitting at all

Standing

- ☐ I can stand as long as I like without extra pain
- ☐ I can stand as long as I like, but it gives me extra pain
- ☐ Pain prevents me from standing more than 1 hour
- ☐ Pain prevents me from standing more than ½ hour
- ☐ Pain prevents me from standing more than 10 minutes
- ☐ Pain prevents me from standing at all

Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ I sleep less than 6 hours because of pain
- ☐ I sleep less than 4 hours because of pain
- ☐ I sleep less than 2 hours because of pain
- ☐ Pain prevents me from sleeping at all

Social Life

- ☐ My social life is normal and causes no extra pain
- ☐ My social life is normal but increases my pain
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to y home
- ☐ I have no social life because of pain

Traveling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it increases my pain
- ☐ My pain is bad but I manage travel of over 2 hours
- ☐ Pain restricts me to short, necessary travel of under 30 minutes
- ☐ Pain prevents me from traveling except to receive treatment

---

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature: (parent if a minor) _____ **Date:** _____

HIPPA Notice:

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your records please inform our office.

Patient's Signature: (parent if a minor) _____ **Date:** _____

(Over please)