Welcome To Chiropractic FIRST

Please Print Clearly and Fill in Completely

CONFIDENTIAL PATIENT HEALTH RECORD Date: _____

PERSONAL HISTORY

Name: _____ Birth Date: _____ Age: _____

Address: _____ Sex: Male / Female

City: _____ State: _____ Zip: _____ Home Phone: _____

Social Security #: _____ Cell Phone: _____

Driver's License #: _____ E-mail Address: _____

Business Employer: _____ Fax #: _____

Occupation: _____ Business Phone: _____

Name of Spouse: _____ Spouse's Employer: _____

Type of Work: _____ Names & Ages of Children: _____

Referred To This Office By: _____ _____

Name & Number of Emergency Contact & Relationship: _____

Current Primary Physician Contact Information _____

Who is responsible for your bill? You and ☐Spouse ☐Worker's Comp ☐Auto Insurance ☐Medicare ☐Medicaid

Personal Health Insurance Carrier: _____ Health Card ID #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: _____ Have you had previous chiropractic care? ☐ Yes ☐ No

Insured Person's Social Security #: _____ Name of Previous Chiropractor: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

VERTEBRAL SUBLUXATIONS CAN PUT PRESSURE ON THE SPINAL CORD THAT FEELS CONSTANT OR OCCASIONAL. WHEN AND WHICH DO YOU FEEL?

☐ Worse AM ☐ Worse PM ☐ Worse with activity ☐ Intermittent ☐ Constant ☐ Worse at night

How often do you find yourself suffering from this problem? _____

How long does the problem last? (Provide all details on timing) _____

Is condition: ☐Auto related ☐Work related ☐Other ☐No injury

Explain: _____

Date/Time of Accident: _____

DAILY ACTIVITIES

Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yardwork	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

SOCIAL HISTORY QUESTIONAIRRE

OCCUPATION

Job Title:_____ **Work Hours Per Day:**_ _____

Max Lifting Requirement: ☐ Min (<5 lbs) ☐ Light (5-20 lbs) ☐ Med (20-50lbs) ☐ Hvy (>50 lbs)
Lifting Frequency: ☐ Constant (66-100%of day) ☐ Frequent (33-66% of day) ☐ Occasional (0-33% of day)
Lifting Postures: ☐ Knee ☐ Torso ☐ Arm ☐ Shoulder ☐ Off Posture
Alcohol: # Drinks per week_____
Tobacco # Packs per week_____

Family

History of Heart Disease? **Paternal** **Maternal**
History of Cancer? **Paternal** **Maternal**
Other? _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes,** how many times? _____
When was the last episode? _____ How did the injury happen?_____
_____
Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment_____,
and who provided it: _____ **How long ago? _____**The results? ☐ Favorable ☐ Unfavorable→
please explain. _____
Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

MEDICATIONS: What prescription(s) and non-prescription(s) are you currently taking and for what condition?_____

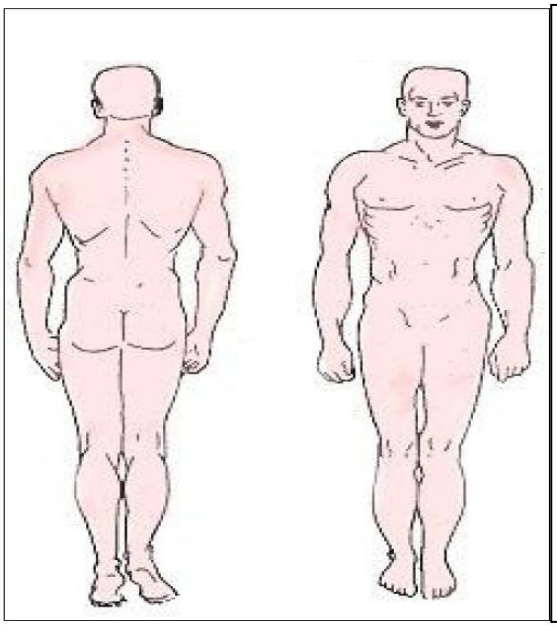
_____

Has there been any other injury to your spine you feel the doctor should know about?_____

_____

Please Fill in Below If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑



PLEASE MARK the areas on the Diagram to the right with the following **letters** to describe your symptoms:

R = Radiating
B = Burning
D = Dull
A = Aching
N = Numbness
S = Sharp/**S**tabbing
T = Tingling

Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____
_____
_____
_____
_____
_____
_____

Thank you for being complete and thorough.

Your Signature Below Please:

_____

Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.