
Patient:

Last Name: _____ First Name: _____ Middle: _____
Gender: M F Date of Birth: ___ / ___ / ___ Age: _____ SS#: _____
Home Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Home Phone #: (____) _____ Work Phone #: (____) _____
Cell Phone #: (____) _____ Email Address: _____
Employer Name: _____ Occupation: _____
Employer Address: _____ Suite #: _____
City: _____ State: _____ Zip: _____

Spouse or Guardian:

Last Name: _____ First Name: _____ Middle: _____
Employer Name: _____ Work Phone #: (____) _____
Date of Birth: ___ / ___ / ___ SS #: _____

Emergency Name and Address of nearest relative or friend **not living with you:**

Last Name: _____ First Name: _____ Middle: _____
Home Phone #: _____ Work Phone #: (____) _____
Relation to Patient: _____

Insurance: When you are done with this form, please bring it along with your insurance card(s) to the front desk to be copied.

Please answer the following questions:

How did you find out about our office? _____
Have you received chiropractic care before? _____ Name of chiropractor: _____
What is the name and location of your primary care physician? _____

Authorization and Release:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees 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 to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Signature: (Patient, Parent, Legal Guardian or Responsible Party)

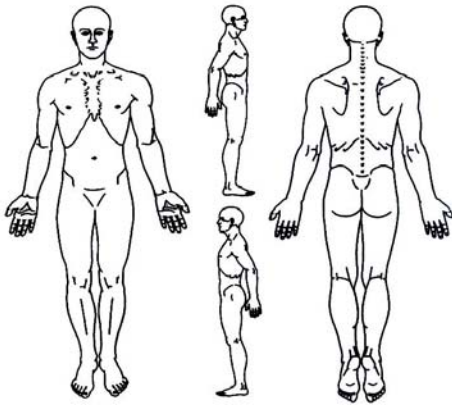
Name: _____ Date _____

CHIEF COMPLAINT

NAME: _____ DATE: _____

PAIN DIAGRAM

Place an "X" below on the area of your Chief Complaint



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

1. Describe the location of your Chief Complaint (where does it hurt?)

2. When (roughly what date) did your present pain start?

3. How did the pain start? (Circle appropriate response(s) or write in below)

Bending	Work Accident
Twisting	Auto Accident
Lifting	Fall

Notes/Other:

4. What makes your pain better? (Circle appropriate response(s) or write in below)

Medication	Rest
Heat	Ice
Movement	Nothing

Notes/Other:

5. What makes your pain worse? (Circle appropriate response(s) or write in below)

Coughing	Sneezing
Movement	Sitting
Bending	Inactivity

Notes/Other:

6. When is your pain the worst? (Circle appropriate response(s) or write in below)

Morning	Evening
Constant	Intermittent
While Sleeping	No Specific Time

Notes/Other:

Name: _____ Date: _____

7. Have you been to any other healthcare providers for this condition? (Circle appropriate response(s) or write in below)

PCP Surgeon Chiropractor Massage Therapist Physical Therapist

Notes/Other: _____

8. Have you had any diagnostic testing for this condition? (Circle appropriate response(s) or write in below)

X-Ray MRI CT/CAT Scan Myelogram Bone Density Scan
 Bone Scan EMG NCV Blood Test Urine Test

Notes/Other: _____

9. Have you experienced this condition before? (Circle appropriate response) Yes No

10. Please add any other information you would like to include. _____

PLEASE DO NOT WRITE BELOW THIS LINE – CONTINUE TO NEXT PAGE

Radiography

Over 50
 Recent trauma
 Previous spinal sx
 Fever
 Night px
 Previous cancer
 Non-remitting or worsening px
 Deformity and stiffness
 Steroid therapy
 Drug or ETOH abuse
 Inflammatory rheumatologic
 Unexplained weight loss
 Changes in bowel or bladder fxn
 Diabetes/hypertension
 Psoriasis/melanoma
 Lymphadenopathy
 Localized pain, tenderness, spasm
 Neurodeficit
 Elevated ESR, Alk/Acid Phos
 RF factor +
 Serum gammopathy

Vitals

BP:	/	Temp:	
Wt:		Pulse:	
Ht:		Resp:	

Muscle Tests

Level	Muscle	Muscle Grade	L	R
C5	Deltoid	L		
C6	Biceps	L		
C6	Wrist Ext	L		
C7	Wrist Flex	L		
C8	Finger Flex	L		
T1	Finger Abd	L		
L3/4	Knee Ext	L		
L4/5	Ankle Ext	L		
L5/S1	Knee Flex	L		
S1/2	Ankle Flex	L		

Range of Motion

Cervical	Normal	Pain
Flex	50	
Ext	60	
LLF	45	
RLF	45	
LR	80	
RR	80	

Lumbar	Normal	Pain
Flex	60	
Ext	25	
LLF	25	
RLF	25	
LR	30	
RR	30	

Sensory (Pinwheel/Light Touch)

	C5	6	7	8	T1	L3	4	5	S1
L									
R									
B									

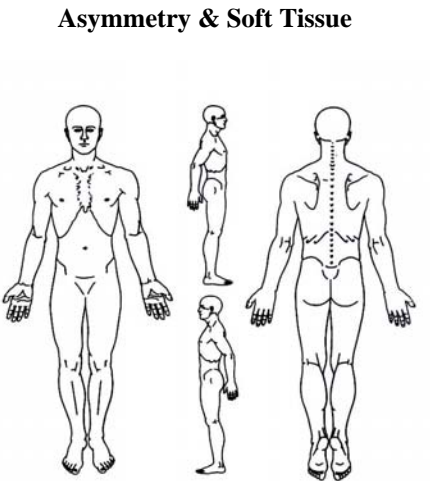
D=Deficit N=Normal

Orthopedic Tests

Cervical	+	-	SOF
Distraction			
Compression			
MCCT			
UENTT			

Lumbar	+	-	SOF
SLR			
Laguerre			
Patrick			
Bechterew			
Nachlas			

Misc	+	-	SOF
Apley			
Minor			
Adam's			
Heel Walk			
Toe Walk			
Valsalva			



Notes

Name: _____ Date: _____

GENERAL MEDICAL HISTORY

Are you affected by any of the following? If yes, please explain. Please include any surgical procedures you may have had.

SYSTEM	NO	YES	EXPLAIN
Heart Disease (including high blood pressure, blood clots, mitral valve prolapse, pacemaker, stroke, etc.)			
Kidney Disease (including dialysis, bladder, etc)			
Lung Disease (including asthma, tuberculosis, pleurisy, rheumatic fever, shortness of breath, etc.)			
Gastrointestinal (including ulcers, hepatitis, jaundice, liver disease, etc.)			
Diabetes			
Neurologic (seizures, paralysis, numbness, weakness, etc.)			
Cancer			
Ear-Eye-Nose-Throat			
Genitourinary (urinary tract infections, incontinence, menopause, etc.)			
Musculoskeletal (broken bones, significant sprains/strains, past trauma, motor vehicle accidents, etc.)			
Female Only Are you pregnant?			If pregnant, what trimester are you in?

LIFESTYLE

- Do you smoke? (circle) Yes No How many packs per day? _____ How many years have you smoked? _____
- How much alcohol do you drink? Number of drinks per week _____
- Do you use any non-prescription drugs? (circle) Yes No
- What is your current occupation? _____
- What is your marital status? (circle) Married Divorced Single Widowed Other

MEDICATIONS AND ALLERGIES

Please list any medications you are taking and any medical allergies that you are aware of: _____

