WELCOME

one

ABOUT YOU

Today's Date: ___/___/___ File #: _____

Name: _____

What You Prefer To Be Called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Home Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Other Phone #s: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____ Work Phone#: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Email address: _____

Preferred Language: ___English ___Spanish Other: _____

two

Current Medications

(List current prescription Meds or NONE)

_____

_____

_____

_____

_____

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

If so, please explain: _____

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ___/___/___

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain: _____

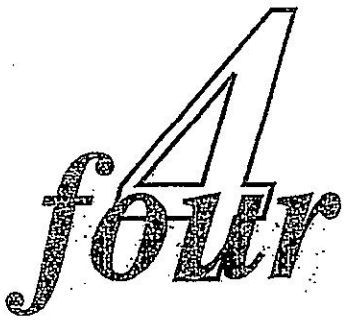
Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? _____

three

RACE

___American Indian or Alaska Native
___Asian
___Black or African-American
___Hispanic or Latino
___Native Hawaiian or Pacific Islander
___White
___Other Race
___Multi-Racial



IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Med. Doctor? _____ Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Have you ever had any of the following diseases/medical conditions(s)?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema /Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones / Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any **past** serious accidents with dates: _____

_____

Family Health History: _____

_____

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? ____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? ____ Nursing? ❑ Yes ❑ No

Allergies to Medication? YES or NO

(List Medications you are allergic to)

Medication: _____

Medication: _____

Medication: _____

Medication: _____

Food: _____

Environmental: _____

- I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).
- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date ___/___/___

PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Smoking Status (age 13 and over):

_____ Current every day smoker

_____ Current occasional smoker

_____ Former smoker

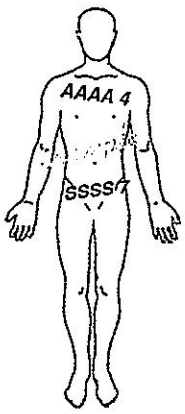
_____ Never Smoked

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

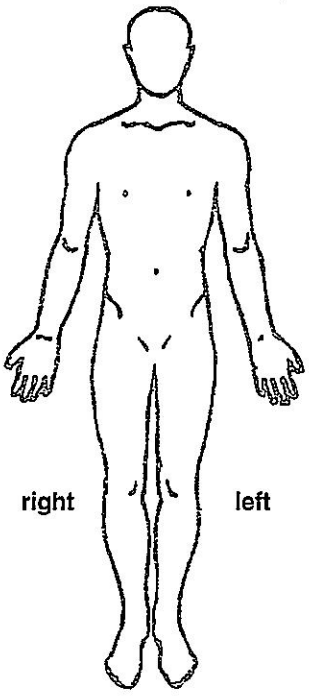
Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



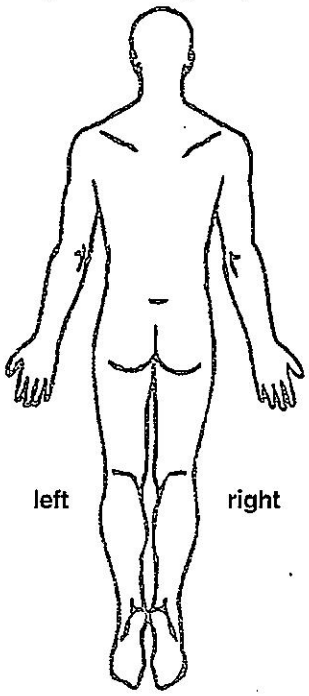
Example

Right



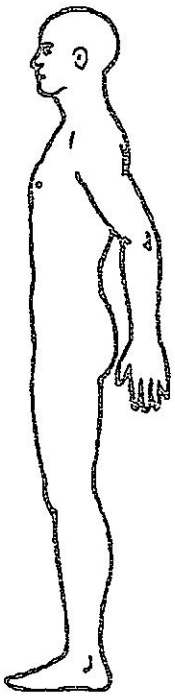
right left

Front



left right

Back



Left

DOCTOR'S NOTES

_____

_____

_____

_____

_____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

Quadruple Visual Analogue Scale (QVAS)

Patient's Name _____ Chart # _____ Date: _____

Instructions: Please circle the number that best describes the question being asked. *Remember, a low number means there is less pain; a higher number means there is more pain.*

The pain I am rating is: (brief description, 'Back pain," "Neck pain," etc.)

_____

1 – Rate your pain RIGHT NOW

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible pain

2 – Rate your TYPICAL OR AVERAGE pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible pain

3 – Rate your pain AT ITS WORST (how close to a "10" does your pain get?)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible pain

4 – Rate your pain AT ITS BEST (how close to a "0" does your pain get?)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible pain

OATS

_____

Examiner

*To calculate Outcome Assessment Tool Score (**OATS**), add first three numbers, divide by 3 and multiply by 10.*

This form is an adaptation of "Quadruple Visual Analogue Scale" *reprinted from* Spine, *18, Von Korff M, Reyo RA, Cherkin D, Barlow SF,* Back pain in primary care: Outcomes at 1 year, 855 862, 1993, with permission from Elsevier Science.