Welcome to Our Office

Last Name: ______________ First Name: ______________ M.I. ______
Address: ______________ City: ______________ State____ Zip: ______
Phone/Home: ( ) ______________ Phone/Work: ( ) ______________
Date of Birth: ______________ Social Security # ______________
E-Mail Address: ______________ Referred ______________
Dominant Hand: ❑ Right ❑ Left ❑ Both Marital Status: ❑ S ❑ M ❑ D ❑ W
Employer: ______________ Occupation: ______________ How Long?______
Employer's Address: ______________
City: ______________ State: ______ Zip: ______

INSURANCE INFORMATION: We will need to copy your Insurance Card and Driver's License for our records.

Date of Injury/Illness or when did your symptoms first appear: ______________
Have you ever been treated by a Chiropractor before: ❑ Yes ❑ No Have you ever had Acupuncture:: ❑ Yes ❑ No
The reason for this visit is a result of (Please Check) ❑ Work ❑ Sports Injury ❑ Auto ❑ Trauma ❑ Chronic Pain
How will you be paying for this visit: ❑ Cash ❑ Credit Card ❑ Insurance

Description of Accident / Injury / Onset of Problem

Enter a full description of the problem you are seeking treatment for and how it happened or started. *Please Print*

____

Are you currently taking **vitamin/mineral** supplements? ❑ Yes ❑ No If so, please list all that you are taking:

1. ______ 4 ______ 7. ______
2. ______ 5. ______ 8. ______
3. ______ 6. ______ 9. ______

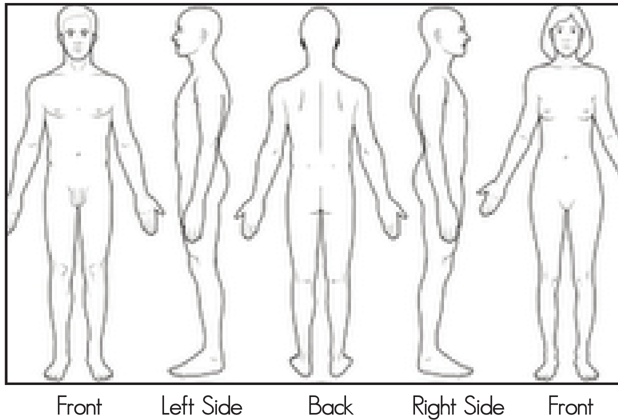
Are you currently taking **medications**? ❑ Yes ❑ No If so, please list all that you are taking:

❑ High Blood Pressure Medication ❑ Diabetic Meds ❑ Cholesterol Meds. ❑ Muscle Relaxants

____

❑ Aspirin ❑ Birth Control Pills ❑ Nerve Pills ❑ Pain Killers . ❑ Blood Thinners ❑ Antacids ❑ Thyroid Meds.
❑ Tranquilizers ❑ Other: ______________

Please indicate the areas of pain or discomfort or the point(s) of injury on the appropriate diagram below



Front   Left Side   Back   Right Side   Front

How often do you experience your symptoms?

- ❑ Constantly - 76 - 100% of the day
- ❑ Frequently - 51 - 75% of the day
- ❑ Occasionally - 26 - 50% of the day
- ❑ Intermittently - 0 - 25% of the day

What describes the nature of your symptoms?

- ❑ Sharp ❑ Numb
- ❑ Shooting ❑ Tingling
- ❑ Dull Ache ❑ Tight / Tense
- ❑ Burning ❑ Throbbing

How are the symptoms changing?

- ❑ No Change ❑ Getting better
- ❑ Getting worse ❑

Severity Scale: On a scale from 1 to 10 - 10 being at it's worst. How bad are your symptoms today?

NONE 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. UNBEARABLE

How do your symptoms affect your ability to perform daily activities?

- ❑ No complaints ❑ Mild, forgotten with activity ❑ Moderate, interferes with activity
- ❑ Limiting, preventing full activity ❑ Intense, preoccupied with seeking relief ❑ Severe, no activity possible

What activities make your symptoms worse?

- ❑ Walking ❑ Driving ❑ Sitting ❑ Standing ❑ Bending
- ❑ Lifting ❑ Cough/Sneeze ❑ Push/Pull ❑ Running

What activities make your symptoms better?

- ❑ Rest ❑ Lying ❑ Aspirin ❑ Cold Pack ❑ Hot Pack
- ❑ Hot Shower ❑ Sitting ❑ Standing ❑ Walking ❑ Exercise

Who have you seen for your symptoms?

- ❑ No one ❑ Chiropractor ❑ Acupuncturist ❑ MD ❑ PT
- ❑ Naprapath ❑ Massage therapist ❑ Other ______________________

When ____________ What treatment did you receive? ______________________________

What tests have you had for your symptoms?

- ❑ X-Rays - Date __________ ❑ MRI - Date __________
- ❑ CT Scan - Date __________ ❑ Other __________ - Date __________

Have you had similar symptoms in the past? ❑Yes ❑No **If yes, who did you see?**

- ❑ No one ❑ Chiropractor ❑ Acupuncturist ❑ MD ❑ PT
- ❑ Naprapath ❑ Massage therapist ❑ Other ______________________

What do you hope to get from your visit / treatment? (select all that apply)

- ❑ Reduce symptoms ❑ Explanation of condition / treatment ❑ How to prevent this from occurring again
- ❑ Resume / Increase Activity ❑ Learn how to take care of this on my own

At what exercise level do you perform? ❑ None ❑ Light ❑ Moderate ❑ Strenuous

Do you smoke? ❑Yes ❑No How Much? ________ • How Long? _______ Have you tried to quit?❑Yes ❑No

Are you wearing: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports ❑ Custom Orthotics

When was date of your last Blood Test ? _______ Date of last cholesterol test? _____ Fecal Occult Blood Test?❑Yes ❑No

Health History

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 check the PRESENT column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
❑	❑	Heart Attack / Stroke	❑	❑	Pacemaker	❑	❑	Arrhythmia
❑	❑	Diabetes	❑	❑	Alcohol/Drug Abuse	❑	❑	Arthritis
❑	❑	Headaches	❑	❑	High Blood Pressure	❑	❑	HIV + AIDS
❑	❑	Neck Pain	❑	❑	Low Blood Pressure	❑	❑	Fainting
❑	❑	Upper Back Pain	❑	❑	Sinus Problems	❑	❑	Digestive Disorders
❑	❑	Mid Back Pain	❑	❑	Congenital Heart Defect	❑	❑	Emphysema
❑	❑	Lower Back Pain	❑	❑	Blood Clots	❑	❑	Asthma
❑	❑	Joint Swelling/Stiffness	❑	❑	Dizziness	❑	❑	Difficulty Breathing
❑	❑	Elbow Pain	❑	❑	Heart Surgery	❑	❑	Epilepsy
❑	❑	Upper Arm Pain	❑	❑	Cancer	❑	❑	Venereal Disease
❑	❑	Wrist Pain	❑	❑	Rheumatic Fever	❑	❑	Ulcers
❑	❑	Ankle Pain	❑	❑	Hepatitis	❑	❑	Cold Extremities
❑	❑	Hand Pain	❑	❑	Anemia	❑	❑	Glaucoma
❑	❑	Sciatica	❑	❑	Artificial Valves	❑	❑	Excessive Thirst
❑	❑	Hip Pain	❑	❑	Chemotherapy	❑	❑	Bladder Infection
❑	❑	Upper Leg Pain	❑	❑	Kidney Problems	❑	❑	Prostate Problems
❑	❑	Numbness in Hands/Feet	❑	❑	Shingles	❑	❑	IBS
❑	❑	Foot Pain	❑	❑	Liver Problems	❑	❑	Gas After Meals
❑	❑	Shoulder Pain	❑	❑	Osteoporosis	❑	❑	Constipation
❑	❑	Artificial Joints	❑	❑	Osteopenia	❑	❑	Weight Gain
❑	❑	Psychiatric problems	❑	❑	Bloating After Meals	❑	❑	Weight Loss
❑	❑	Fatigue	❑	❑	Diarrhea	❑	❑	Depression
❑	❑	Visual Disturbances	❑	❑	Gall Bladder Disorder	❑	❑	Chest Pains
❑	❑	Painful Urination	❑	❑	Loss of Bladder Control	❑	❑	Tumor

Indicate if an immediate family member has had any of the following: ❑Heart Problems ❑Diabetes ❑Cancer ❑Rheumatoid Arthritis

Please list any other serious medical conditions you may have ever had:

List previous surgeries with dates: ______________________________

For Women: Are You:

Taking birth control pills?	❑Yes	❑No
Pregnant?	❑Yes	❑No
Nursing?	❑Yes	❑No
Menstrual Cramping?	❑Yes	❑No
Cramps in Calves at Night?	❑Yes	❑No
Back Pain during Menses?	❑Yes	❑No

Date of last PAP Smear :____________

Date of last Mammography Test: ________________

For Men: Do you have:

History of Prostate Problems?	❑Yes	❑No
Low Back Pain?	❑Yes	❑No
Difficulty Urinating?	❑Yes	❑No
Painful Urination?	❑Yes	❑No
Blood in Urine?	❑Yes	❑No

How many times do you awake to urinate? _______ times

❑ Our policy requires payment in full for all services rendered at the time of visit. unless other arrangements have been made. If account is not paid within 90 days from the date of service & no financial arrangements have been made,you will be responsible for any expenses incurred in collecting your account.

❑ I authorize the staff to perform 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 proof of any changes in my medical status.

❑ If this is an accident, personal injury, workmen's comp or attorney involved case I hereby give a lien on any settlement, claim, judgement, or verdict as a result of said accident/illness and authorize and direct my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing doctor for all services rendered me.

❑ As required by HIPPA regulations, I acknowledge that I have read Americare Notice of Privacy Practices.

Signature ____ Date: ____________________

Functional Rating Index

For Use With NECK and/or BACK Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition RIGHT NOW.

#	Item	0	1	2	3	4
1.	PAIN Intensity:	No PAIN	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain
2..	Sleeping:	Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep
3..	Personal Care (washing, dressing, etc.)	No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go Slowly	Moderate Pain Needed Some Assistance	Severe Pain Needed 100% Assistance
4..	Travel: (driving , etc.)	No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips
5.	Work:	Can Do Usual Work Plus Unlimited Extra Work	Can Do Usual Work, No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work
6.	Recreation:	Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities
7.	Frequency Of : PAIN	No Pain	Occasional Pain 25% of The Day	Intermittent Pain 50% Of The Day	Frequent Pain 75% Of The Day	Constant Pain 100% Of The Day
8.	Lifting:	No Pain With Heavy Lifting	Increased Pain With Heavy Lifting	Increased Pain With Moderate Lifting	Increased Pain With Light Lifting	Increased Pain With Any Weight
9.	Standing:	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After 1/2 Hour	Increased Pain With Any Standing

Patient's Signature ______________________________ Date: ________________