

# CHIROMEDICAL GROUP

## PATIENT HEALTH ASSESSMENT AND APPLICATION FOR TREATMENT

WELCOME TO OUR OFFICE - PLEASE PRINT OR WRITE CLEARLY

PATIENT NAME				DATE	
PATIENT ADDRESS			CITY		STATE
ZIP			AGE		SS#
SEX	M	F	DATE OF BIRTH		
HOME PHONE		WORK PHONE		MOBILE PHONE	
PREFERRED NUMBER		REFERRED BY			
EMAIL		PRIMARY CARE PHYSICIAN		ADDRESS	
PHONE		PATIENT EMPLOYER			
PATIENT OCCUPATION				SUBSCRIBER NAME	
RELATION TO PATIENT				SUBSCRIBER EMPLOYER	
SUBSCRIBER'S SS#				HEALTH INSURANCE PLAN	
GROUP #				MEMBER#	

### COMPLAINT HISTORY

DESCRIBE YOUR CURRENT COMPLAINT AND HOW THE PROBLEM BEGAN:

HOW LONG HAVE YOU HAD THIS CONDITION? DATE OF ONSET

HOW DO YOU DESCRIBE THE PAIN?

sharp    spasm    soreness    burning    throbbing    ache  
tingling    weakness    dull    numbness    stiffness    shooting

CIRCLE THE INTENSITY OF YOUR PAIN. 0 = No Pain; 5 = Moderate Pain; 10 = Unbearable Pain

0    1    2    3    4    5    6    7    8    9    10

HOW OFTEN IS YOUR PAIN PRESENT?

Intermittent (25% or less)    Occasional (26-50%)    Frequent (51-80%)    Constant (81-100%)

HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR DAILY ACTIVITIES? 1 = Mild Interference; 10 = Unable To Do

1    2    3    4    5    6    7    8    9    10

SINCE THE PROBLEM BEGAN IS YOUR PAIN: HOW DID YOUR PROBLEM BEGIN?

getting worse    getting better    staying the same    gradual    sudden    car accident    work    other

WHAT MAKES YOUR PROBLEM BETTER?

nothing    walking    standing    sitting    laying down    movement    inactivity

WHAT MAKES YOUR PROBLEM WORSE?

nothing    walking    standing    sitting    laying down    movement    inactivity

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

HAVE YOU PREVIOUSLY HAD TREATMENT FOR THIS SAME CONDITION?

Yes    No    If yes, please describe: MD    Chiropractor (DC)    Physical Therapy (PT)    Other

WHAT WERE THE APPROXIMATE DATES, TYPES OF TREATMENT, AND THE RESULTS?

WHAT IS YOUR DAILY PHYSICAL ACTIVITY?

mostly sitting    light office    light manual labor    moderate manual labor    heavy manual labor

DO YOU EXERCISE?

No    1-2 times per week    3-4 times per week    5-7 times per week

TYPE OF EXERCISE:

Cardiovascular    Strengthening    Yoga/Stretching    Types of Sports:

WHAT IS YOUR PRESENT GENERAL STRESS LEVEL?

None    Minimal    Moderate    Greatly Stressed

IS YOUR CURRENT CONDITION AFFECTING YOUR ABILITY TO WORK OR DO ROUTINE DAILY ACTIVITIES?

Yes    No    If yes, describe:

### DOCTOR USE ONLY

Over, please →

# PAST OR PRESENT SYMPTOMS, CONDITIONS, OR HABITS

IF APPLICABLE, PLEASE CHECK THE BOX INDICATING WHETHER THESE SYMPTOMS, CONDITIONS, OR HABITS APPLY TO THE PAST OR PRESENT

CONDITION	PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION	PAST	PRESENT
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Ovaries	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin Condition	<input type="checkbox"/>	<input type="checkbox"/>	Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate	<input type="checkbox"/>	<input type="checkbox"/>	Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Uterus	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	PAST	PRESENT	OCCASIONAL	MODERATE	HEAVY	CONDITIONS	PAST	PRESENT
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Due Date: \_\_\_\_\_  
Please list: \_\_\_\_\_

PLEASE INDICATE IF A CLOSE FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING DISEASES

	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER
Adopted <input type="checkbox"/>						
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MY ATTITUDE TOWARDS BEING HERE IS:

- Hopeful and Interested
- Fearful
- Skeptical
- Other: \_\_\_\_\_

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly and mutual understanding between provider and patient.

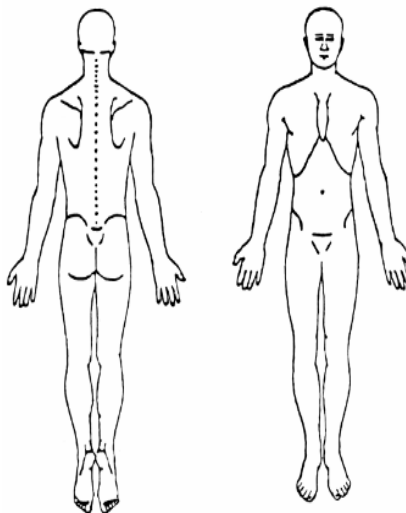
I authorize the ChiroMedical staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or insurance company to release any information required to process insurance claims.

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 to the information I provided.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

PLEASE SHADE IN THE AREA WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



## DOCTOR USE ONLY

### Patient Goals

I have reviewed the information contained on this form with the patient.

Provider Initials: \_\_\_\_\_

Date: \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_