(Complete with blue ink pen) (MR #: __________ completed by staff)

Last Name ____________________________ First Name ______________________________ **Date ____/____/____**

Address ____ City____________________ Zip ______________

Home Phone __________________Cell Phone ____________________Email ________________________________

Birthday ___/____/____ Sex: M/F Marital Status:______ Spouse's or Significant Other's Name _________________

Occupation:___________________________________ Employer:____

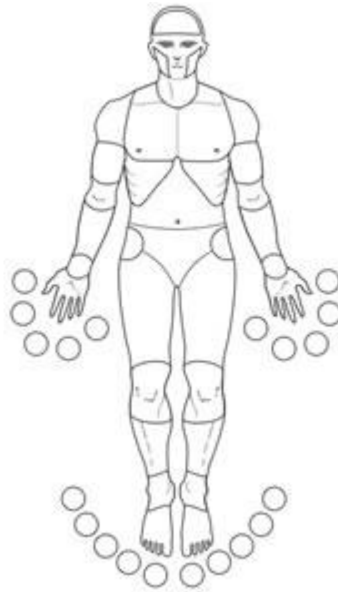
Emergency Contact (name) ____________________ (phone) _________________ (relationship) _________________

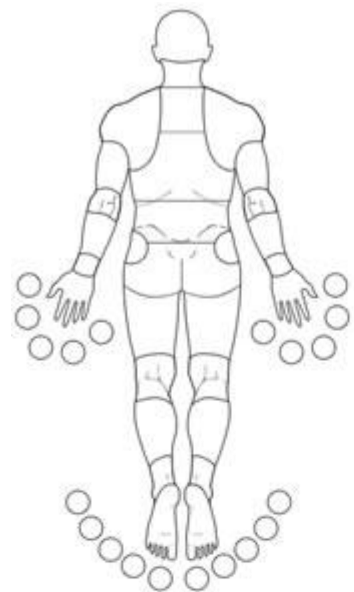
How did you hear about our clinic? ____

How would you like to receive appointment reminders? ☐ E-mail ☐Text (Cellular Carrier ________________) ☐None

On the diagrams to the right, please mark where you are experiencing any symptoms:

Use the following as a guide:
P = Pain
T = Tingling
N = Numbness
B = Burning
W = Weakness





Please rate each of your symptoms individually on a scale of 0-10. (0 = no pain, 10 = worst pain you've ever had)

Symptom #1:____ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Symptom #2:____ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Symptom #3:____ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Symptom #4:____ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Symptom #5:____ ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

When did your symptoms begin?____

Are your symptoms getting progressively worse?: ☐Yes ☐No ☐Unknown

How often do you have this pain? ____

Is it constant or does it come and go? ____

How would you characterize your pain? (check all that apply): ☐Dull ☐Sharp ☐Achy ☐Shooting ☐Burning

☐Stabbing ☐Throbbing ☐Stiffness ☐Other____

What makes your condition <u>worse</u>? ☐Coughing ☐Sneezing ☐Bearing Down ☐Lifting ☐Bending ☐Pushing

☐Pulling ☐Sitting ☐Standing ☐Lying Down ☐Walking ☐Moving Your Head ☐Other_____________________

What makes your condition better? □Rest □Movement □Sitting □Standing □Lying Down □Bracing □Heat □Ice □Massage □Stretching □"Popping" □Aspirin □Ibuprofen □Tylenol/Acetaminophen □Prescribed Medication □Other____

What time of the day are your symptoms worse? □Morning □Afternoon □Evening □ Sleeping □At Work □Other____

What time of the day are your symptoms better? □Morning □Afternoon □Evening □ Sleeping □At Work □Other____

Is there any known cause of your symptoms? □Auto Accident □Work Injury □Lifting □Slip/Fall □Overexertion □Strenuous Position □Unknown □Other____

If known cause, how soon did the symptoms start? □Immediately □Hours Later □Next Day □Days Later □Week Later □Other:____

Have you experienced symptoms like these before? □No □Yes (when?)______________________

Have you missed any work due to this condition? □No □Yes (dates?)______________________

Have you had to modify or restrict your activities at work? □No □Yes

When your symptoms are at their worst, describe what happens:______________________

____

Previous Testing:

Have you had any of the following testing?

X-ray: Y/N Area:____________ Date: __________ MRI: Y/N Area: _________ Date: ____________

CT Scan: Y/N Area:____________ Date___________ EMG/NCV: Y/N Area: _________ Date: ____________

Was there a previous diagnosis for your condition? i.e. Have you been told what is causing your problem?__________

____

Previous Treatment:

Have you ever seen anyone else for this condition? □Yes □No

If Yes, who and when?____

____

Treatment Options:

Is there any type of treatment that you would not consider at this time? ______________________

____

What is your most important treatment objective? (Reduce pain, increase function, correct cause, prevent progression) ____

Prescription Medications	Supplements	Allergies
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
□ See attached list	□ See attached list	

Previous/Current Conditions:

Do you currently have or have you ever had any of the following? (check all that apply)

☐Alcoholism	☐Diabetes	☐HIV/AIDS	☐Rash/Lesion
☐Aneurysm	☐Dislocated Joints	☐Thyroid Hyper/Hypo	☐Rheumatic Fever
☐Anemia	☐Easily Bruised	☐Insomnia	☐Scoliosis
☐Arthritis___________	☐Emphysema	☐Kidney Trouble	☐Spinal Disc Disease
☐Asthma	☐Epilepsy/Seizures	☐Liver Trouble	☐STD
☐Bone Fractures ___________________	☐Erectile Dysfunction	☐Mental/Emotional Difficulty:___________	☐Stroke
	☐Fatigue/weakness		☐Tinnitus/Ears Ringing
☐ Blood Pressure HIGH/LOW	☐Frequent Nose Bleeds	☐Multiple Sclerosis	☐Tuberculosis
		☐Osteoporosis/ Osteopenia	☐Ulcer
☐Cancer/Tumor	☐Hearing Changes		☐Other____________ ___________________
☐Carotid Artery Disease or Blockage	☐Heart Disease	☐Pacemaker	
	☐Heart Palpitation	☐Polio	☐ **None of the above**
☐Change in Appetite	☐Hernia	☐Prostate Trouble	

Have you had any of the following in the last 3 months? (check all that apply)

☐Neck Pain	☐Upper Back Pain	☐Mid Back Pain	☐Low Back Pain	
☐Neck Stiffness	☐Upper Back Stiffness	☐Mid Back Stiffness	☐Low Back Stiffness	
☐Shoulder Pain	☐Hip Pain	☐Leg Pain	☐Ankle Pain	☐Foot Pain

Vascular Screening:

Have you recently experienced any of the following? (mark all that apply):

☐ Double Vision / Sudden Onset of Vision Problems	☐ Dizziness, Vertigo or Light-headedness
☐ Sudden Numbness/Weakness of Face, Arms or Legs	☐ Difficulty Speaking
☐ Difficulty Swallowing	☐ Difficulty Walking
☐ Nausea, Vomiting or Queasiness	☐ Numbness or Loss of Sensation on one side
☐ Involuntary Rapid Eye Movements (nystagmus)	☐ **None of the above**

If you are experiencing Headaches or Neck Pain, have you experienced pain like this before?

☐Yes, I have had headaches / neck pain like this before.

☐No, this pain is different than I have experienced in the past.

Did your headache or neck pain start suddenly? Y / N

Women Only:

Is there any chance that you may be PREGNANT? Y/N Date of last menstrual period ____/____/____

Lifestyle & Habits:

Smoking (packs per day): ☐Never ☐1 ☐2 ☐3 ☐4+ ☐Quit______ years ago.

Caffeinated drinks (cups per day): ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6+

Alcohol consumption (drinks per day): ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6+

Drug/Substance use: ☐Yes ☐No

Exercise (times per week): ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 Type of exercise:________________________________

Average amount of sleep per night (hours): ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12

What do you feel your stress level is currently? (0 being no stress and 10 being maximal stress)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Previous Accidents/Injuries/Hospitalizations/Surgeries:

(Please inform us of any/all recent injuries that could have contributed to your current condition.)

Do you have a history of any of the following? ☐Work Injury ☐Auto Accident ☐Slip & Fall Accident

If so please list approximate dates and incident:

1. Date____/____/____Incident____

2. Date____/____/____Incident____

Have you ever been hospitalized? ☐Yes ☐No If so, when and for what condition?

1. Date____/____/____Condition____

2. Date____/____/____Condition____

Have you had any surgeries? ☐Yes ☐No If so, when and for what condition?

1. Date____/____/____Surgery____

2. Date____/____/____Surgery____

Family History:

Has any member of your family been diagnosed with any of the following?

☐Cancer ☐Diabetes ☐High Blood Pressure ☐Stroke ☐Heart Disease ☐Other: ______________________________

If yes, what is their relation to you?______________________________

Have you tried any of the following?				**Results of treatment: (circle one for each)**		
Anti-Inflammatory Meds:	YES	NO	►►	No Relief	Temporary Relief	Worse
Muscle Relaxers (Prescription):	YES	NO	►►	No Relief	Temporary Relief	Worse
Pain Medications (Prescription):	YES	NO	►►	No Relief	Temporary Relief	Worse
Massage Therapy:	YES	NO	►►	No Relief	Temporary Relief	Worse
Physical Therapy:	YES	NO	►►	No Relief	Temporary Relief	Worse
Acupuncture:	YES	NO	►►	No Relief	Temporary Relief	Worse
Chiropractic:	YES	NO	►►	No Relief	Temporary Relief	Worse
Injections (including epidurals):	YES	NO	►►	No Relief	Temporary Relief	Worse
Spinal Surgery:	YES	NO	►►	No Relief	Temporary Relief	Worse

Have you been told you need an injection? YES NO By whom? ___________________________________

Have you been told you need spinal surgery? YES NO By whom? ___________________________________

What three things has this condition caused you to miss out on the most?

1) ______________________________ 2) ______________________________ 3) ______________________________

What is your biggest concern if you are unable to find a solution to your main problem?

____

Please indicate how important it is for you to improve your current condition, or stop it from progressing:

Not Important *Very Important*

0 1 2 3 4 5 6 7 8 9 10

Activities of Daily Living

This next series of questions are about the effect your condition has had on your activities of daily life. We also will use this information to measure your progress and the results of your treatment if we are able to accept you for care.

Work:

How do your health problems make it harder to do your job?____

____

Are you less productive on your job because of your health problems? □Yes □No

Do you enjoy work less? □Yes □No

Do you have to take more breaks? □Yes □No

Are you concerned about your ability to do your job or the security of your job? □Yes □No

Please explain:____

Social:

How do your health problems affect your relationships with your family and friends? For example: Are you less fun to be with? Do you help less around the house? Are there things you do less?____________________________

____

Recreational Activities:

What hobbies or interests do you have outside of work?____

____

When your problems are at their worst, do they affect how you do or enjoy your hobby/interest? □Yes □No

If you didn't have this condition how would it affect how you do your hobbies/interests?_________________________

____

Is there anything else you would do more of or just enjoy more if it wasn't for these conditions?__________________

____

____

Sleep Habits:

Do you have trouble falling asleep due to being uncomfortable? Y/N

How long does it take to fall asleep?_________

Do you wake during the night? Y/N Approximately how many times?__________ Can you get back to sleep? Y/N

Additional Information & Resources

If you are interested in receiving additional information about any of the following, please check the boxes below:

Conditions	**Treatments**
☐ Peripheral Neuropathy	☐ Non-Surgical Spinal Decompression
☐ Sciatica	☐ Cold Laser
☐ Chronic Headaches	☐ Massage Therapy
☐ Dizziness/ Balance Disorders	☐ Clinical Nutrition
☐ Whiplash Injuries	☐ Functional Neurology
☐ Mild Traumatic Brain Injury	☐ Vitamins/ Supplements
☐ Chronic Back/Neck Pain	☐ Infrared Therapy
☐ Joint Pain (Hip, Knee, Foot, Shoulder, Elbow, Hand)	☐ Whole Body Vibration
	☐ Interactive Metronome

FINANCIAL POLICY

As a courtesy to you, we will bill your insurance company for you. In order for us to do this for you, we will need you to provide us with the following information: the name of the company, the address to which claims are to be billed, your policy identification number, your group number (if applicable), and a phone number. It is your responsibility to provide any required information (referrals, authorization numbers, claim forms, accident information). It is also your responsibility to follow the policy guidelines of your insurance company. We will bill your secondary insurance as well, provided you have given us complete insurance information as noted above for your secondary company.

Policies vary widely on which procedures, services or items an insurance company will cover. Because policies are often customized, we cannot be sure what your policy covers. In order to maximize your health insurance benefits, it is very important that you familiarize yourself with the policies and benefits outlined in your health insurance handbook or contact the customer service number on the back of your card.

Insurance Company & Phone: ____

Member ID ___________ Group #:________ Name & Date of Birth of ***Policy Holder***: ____________________

AUTHORIZATION OF RELEASE, ASSIGNMENT OF BENEFITS, STATEMENT OF RESPONSIBILITY

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable. I understand that if I have insurance, the fees for services I receive will be billed to my insurance company. I also understand that I am responsible for coinsurance or copays at the time I receive the service, unless prior arrangements have been made.

I have read and understand the terms and conditions stated above.

Patient Name or Responsible Party: ____________________________________Date: ____________

(Signature)