# Back Pain, Neck Pain, & Headache Relief Center

Name ______________________ Address ______________________

City __________ State ______ Zip ________ Home phn ____________ Cell phn ____________

Pager ____________ E-mail Home: ______________________ E-mail Work: ______________________

SSN ______________ Date of birth ____________ Age ________ Height ________ Weight ________

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ # of children ________ Name of spouse (or parent) ______________________

Employer ______________________ Address ______________________

City __________ State ______ Zip ________ Wk phn ____________ Occupation ____________

What is the name of your family physician? ______________________ What city are they located in? ____________

Have you ever had Chiropractic care before? _____ If yes, doctor name: ______________________ Date of last visit ____________

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity

1. ______________________ For how long? ______________________

2. ______________________ For how long? ______________________

3. ______________________ For how long? ______________________

4. ______________________ For how long? ______________________

Has this problem been getting worse or staying the same? ______________________

Currently or in the past have you ever experienced any of these complaints while working? ______ If yes, please describe what activities at work may be causing you to experience these complaints: ______________________

Are there any other activities, incidents, or events outside of work that may have caused these complaints? ____________ If yes, please explain:

______________________________________________

Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of injury? ______________________

Do you have an attorney representing you for this work injury? ___ Yes ___ No If yes, who is your attorney? ______________________

Have you been involved in an auto accident in the last 12 months? ___ Yes ___ No If yes, what is the date of the auto accident? ____________

Do you have an attorney representing you for this auto accident? ___ Yes ___ No If yes, who is your attorney? ______________________

How many other passengers were in the car with you? ______________________

List other doctors consulted for these conditions: 1. ______________________ 2. ______________________

If due to an auto accident, what is the name of your auto insurance company? ______________________

Have you ever had any surgeries or hospitalizations? ______ If yes, please list: ______________________

Please list any current or past injuries and illnesses not listed above: ______________________

Please check all medications (over the counter and/or prescribed) you are currently taking: ☐ Aspirin/Tylenol ☐ Pain killers ☐ Muscle Relaxers

☐ Insulin ☐ Birth Control Pills ☐ Sleeping pills ☐ Anti-Depressants ☐ Others ______________________

Health Insurance Co. Name ______________________ Policyholder ______________________

Name of Spouse's health insurance (If applicable) ______________________ Policyholder ______________________

Spouse's Health Insurance Claims address ______________________ Policy number ______________________

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Completely able to function | | | | | | | | | | Totally unable to function |

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) ______
2. RECREATION: hobbies, sports, and other similar leisure time activities. ______
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. ______
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. ______
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) ______
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. ______

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS

Method of payment for today's charges: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ ____________________

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature ______________________________ Date ____________________