FOR OFFICE USE ONLY:
Patient Number: _____
Doctor: _____
Insurance: _____
Emp. Initials: _____

CHIRO YEARLY REVAL:
PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records.****
Patient Name: Last _____ First _____ Date _____ / _____ / _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: (_____) _____ - _____ Home Phone (_____) ____ - _____ Birth date ____ / ____ / ____ Age ____
Sex: ____M ____F Driver's License: _____ Patient Soc. Sec. # _____ - _____ - _____
Marital Status: S M D W Spouse's Name: _____ Referred by: _____
Person responsible for payment: _____ Patient Employed by: _____
Occupation: _____ Work Phone: (____) ____ - _____
Email: _____
Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email
Have you ever been to a Chiropractor before?: YES NO
Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation

CHIEF COMPLAINT: **Answer the questions as completely as possible. If a question does not apply, leave it blank.**

Reason for today's appointment: ☐ Neck pain ☐ Upper back pain ☐ Low back pain ☐ Other: _____

Which side of your body is the complaint on? ☐ Right ☐ Left ☐ Both

How long have you had this problem?
Date: _____ or _____day(s) _____ week(s) _____ month(s) _____ year(s)

How do you think your problem began?
_____

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (50-75%) ☐ Occasionally (26-49%) ☐ Intermittently (0-25%)

Rate the severity of your symptoms:
☐ Mild ☐ Moderate ☐ Severe

How does this effect your movement?
☐ Stiffness ☐ Spasms ☐ Cramps

What makes the symptoms worse?
_____

What makes the symptoms better?
_____

Please add any other information about the primary complaint that may be helpful:
_____

*****Please list any ADDITIONAL complaints that you have: (Other areas of pain, etc.)*****
_____

If you are being RE-EVALUATED ONLY:
What percentage of improvement have you had from 0-100%: _____ %

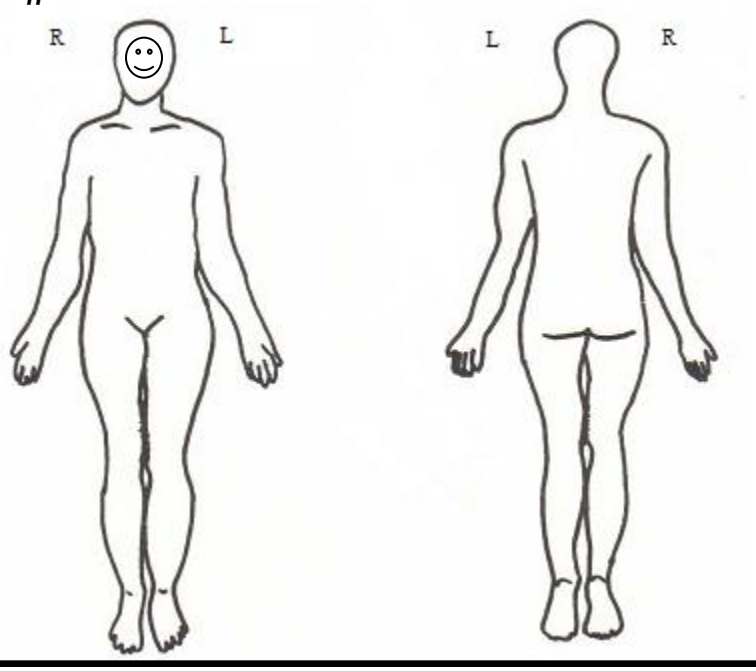
PATIENT'S INITIALS_____DATE_____

PAIN DRAWING:

INSTRUCTIONS: ***Mark the area on your body where you feel the described sensations:***

- ***Use the appropriate symbol***
- ***Mark the areas of spread***
- ***Include all affected areas***

KEY:	
Numbness / Tingling	=======
Pins & Needles	oooooooo
Burning pain	xxxxxxxx
Dull / achy pain	……
Sharp / Stabbing pain	///////////////



VISUAL PAIN SCALE

INSTRUCTIONS: ***Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, at its worst and at its best.***

Example:

Headache *Neck* *Low back*

No Pain ——— **Worst pain**

0 (1) 2 3 4 (5) 6 7 8 (9) 10

What is your pain RIGHT NOW?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its BEST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its WORST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

PATIENT'S INITIALS_____DATE_____

REVIEW OF SYSTEMS: Please CIRCLE any condition that you CURRENTLY HAVE. Or check NONE ☐.

ALLERGIC/IMMUNOLOGIC: ☐ **NONE** Food Allergies Frequent sinus problems Hay fever Hives

CARDIOVASCULAR: ☐ **NONE** Ankle swelling An unusually slow pulse Blood clots Blue extremities Chest pain Cold hands/feet Feeling light headed with standing Heart murmur Heart problems High blood pressure High cholesterol Leg pain with walking Low blood pressure Palpitations (heart skipping beats) Poor circulation Rapid heartbeat Sores that don't heal Taking nitroglycerine Varicose veins

CONSTITUTIONAL: ☐ **NONE** Chills Difficulty concentrating Difficulty sleeping Fatigue Fainting Fever Low libido Nervousness Night Sweats Poor appetite Side effects from medications Sudden weight loss Sudden weight gain Weakness

EARS, NOSE &THROAT: ☐ **NONE** Bleeding gums Blisters/cold sores Chronic ear infection Dental problems/toothaches Deviated septum Dry mouth Dysphagia Ear discharge Ear noises/ringing Ear pain Frequent colds Gum disease Halitosis Hearing loss Loss of smell Loss of taste Loss of teeth/ have dentures Motion sickness Nose bleeds Nasal breathing problems Nasal drip Nasal polyps Punctured ear drum Recurrent ear infections Sinus infections Sinus pain Sneezing spells Sore throat/hoarseness Sore tongue Sores or cracks at mouth corners Sores/ulcers Tongue badly coated Tonsillitis Vertigo/dizziness

ENDOCRINE: ☐ **NONE** A loss of appetite Being tired most of the time Being unusually jumpy or nervous Changes in hair growth or distribution Cold intolerance Excessive hunger Excessive thirst Extreme Thinness Feeling drowsy after eating Feeling shaky or faint when hungry Frequent infections Heat intolerance Hoarseness Hyperthyroid Hypothyroid Needing to eat to relieve fatigue Type I diabetes Type II diabetes Unexplained weight gain Unexplained weight loss

EYES: ☐ **NONE** Sensation of burning in the eyes An injury to the eyes Blurred vision Cataracts Crossed eyes Dry or gritty eyes Far sightedness Glaucoma Itchy eyes Near sightedness Redness Swelling Tearing/crusting Vision headaches

GASTROINTESTINAL: ☐ **NONE** Abdominal gas Abdominal pain Acid reflux Anorexia/Bulimia Belching or burping after meals Black or tarry stools Constipation Diarrhea Difficulty in swallowing Food sensitivities Frequent indigestion Gall bladder disease Having one or less bowel movements Heartburn Hemorrhoids Intestinal worms Liver trouble Nausea Pain or indigestion after eating greasy foods Pale or yellow stools Stomach ulcers Ulcer Vomiting

GENITOURINARY: ☐ **NONE** A discharge other than urine Bedwetting Bladder control problems Cloudy/foul smelling urine Difficulty starting a stream Discolored urine Dribbling Erectile dysfunction Frequent urination Getting up at night to urinate Infertility Kidney stones Kidney or bladder infections Painful urination PMS symptoms Urgency Uterine cysts Uterine fibroids

HEMATOLOGIC/LYMPHATIC: ☐ **NONE** Anemia Bleeding or bruising Blood clots Hemophilia Hepatitis A Hepatitis B Hepatitis C HIV/AIDS Jaundice Liver problems Lymphoma Myeloma Swollen Glands

INTEGUMENTARY/SKIN: ☐ **NONE** Acne Boils Bruising Coarse or bumpy skin Corns Dandruff Dryness Eczema Excessive perspiration Hair changes Hair loss Itching Nail bed changes Nail fungus Plantar warts Psoriasis Rashes Skin cancer Sores

MUSCULOSKELETAL: ☐ **NONE** Arthritis Back injuries Back pain Frequent foot cramps General muscle tension Heel spurs Hot joints Joint pain Joint stiffness Joint swelling Leg cramps during the day Leg cramps when retiring to bed or at night Muscle cramps Muscle pain Muscle twitching Muscle Weakness Neck injuries Pain between the shoulders Painful feet Rheumatism Scoliosis Tender ribs TMJ pain

NEUROLOGICAL: ☐ **NONE** Confusion Convulsions Difficulty of speech Dizziness/vertigo Double vision Epilepsy Fainting spells Forgetfulness Hand trembling Headaches Incoordination Losing consciousness Loss of feeling Memory loss Meningitis Muscle jerking/twitching/tics Numbness/tingling Paralysis Pins/needles Seizures Stuttering

PSYCHIATRIC: ☐ **NONE** Alcoholism Anxiety Being timid or shy Considerable emotional stress Crying often Depression Drug addictions/dependency Eating when nervous Extreme worry Feeling angered or irritable Feeling miserable or blue Frequent hyperventilation Hallucinations Insecurity Nail biting Phobias Recurrent bad dreams Sleep walking Suicidal thoughts

RESPIRATORY: ☐ **NONE** Apnea Asthma Chronic cough Congestion COPD Coughing up blood Difficulty breathing Emphysema Hay fever Non-productive/dry cough Pain upon expiration Pain upon inspiration Phlegm Pneumonia Productive cough Severe colds Shortness of breath Wheezing

PATIENT'S INITIALS_____DATE_____

SOCIAL HISTORY: Please answer as completely as possible.

Marital Status: _____

Number of children: ____ Number of Pregnancies: ____ Number of miscarriages: ____ Number of abortions: ____

Highest level of education: _____

Do you feel that you eat a well-balanced diet? _____

How often do you exercise? _____ What types of exercises? _____

How often do you drink alcohol? _____

If you smoke cigarettes, how often? _____ If you chew tobacco, how often? _____

Have you ever used illegal drug? (circle) YES NO

If you use illegal drugs now, which ones? _____

Have you ever been treated for substance abuse? (circle) YES NO

Are your vaccinations up to date? (circle if known) YES NO

SURGICAL HISTORY:

Please list any surgeries that you have had in the past and the date if known. Also INCLUDE RIGHT OR LEFT side of body where applicable.

- □ **I have never had any previous surgery**

PROCEDURE:	DATE:	PROCEDURE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Please list any allergies as well as your reaction to the allergen if known.

Enviromental: _____
Food: _____
Medication/Drug: _____

CURRENT MEDICATIONS:

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

KEELE STarT NECK SCREENING TOOL

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1. My neck pain has **spread down my arm(s)** at some time in the last 2 weeks	☐	☐
2. I have had pain in the **hip** or **back** at some time in the last 2 weeks	☐	☐
3. I have **dressed/washed** more slowly because of my neck pain	☐	☐
4. In the last few days, I my sleeping is moderately disturbed because of neck pain	☐	☐
5. It's not really safe for a person with a condition like mine to be physically active	☐	☐
6. **Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7. I feel that **my neck pain is terrible** and **it's never going to get any better**	☐	☐
8. In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your neck pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐

Total score (all 9): _____ Sub Score (Q5-9): _____

Funded by Arthritis Research UK

PATIENT'S INITIALS_____DATE_____

KEELE STarT BACK SCREENING TOOL

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1. My back pain has spread down my leg(s) at some time in the last 2 weeks	☐	☐
2. I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks	☐	☐
3. I have only **walked short distances** because of my back pain	☐	☐
4. In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
5. It's not really safe for a person with a condition like mine to be physically active	☐	☐
6. **Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7. I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
8. In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐

Total score (all 9): _____ Sub Score (Q5-9): _____

Funded by Arthritis Research UK

PATIENT'S INITIALS_____DATE_____