

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: _____ Emergency Contact Name / # / Relationship: _____ / _____ / _____

Primary Care Physician/Facility: _____ Primary Care Phone: _____

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

ARE YOU CURRENTLY PREGNANT? YES NO

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%) Intermittently (26-49%) Occasionally (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:

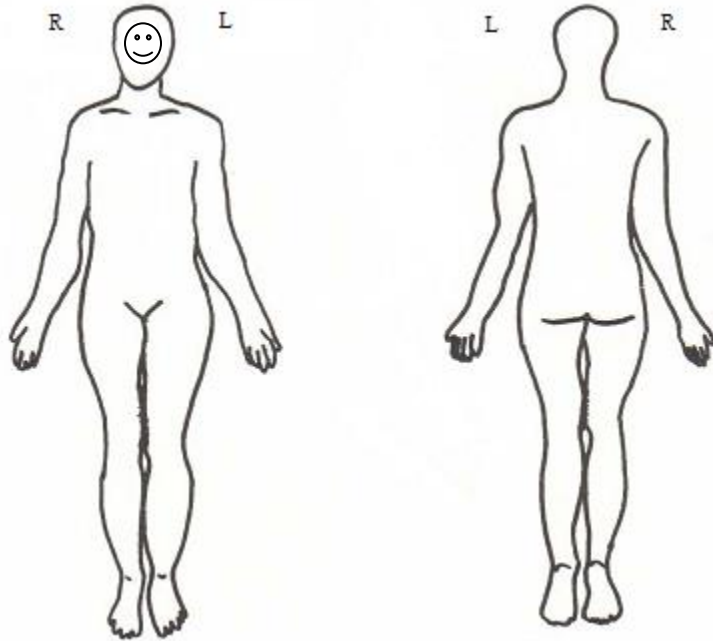
What percentage of improvement have you had from 0-100%: _____ %

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*

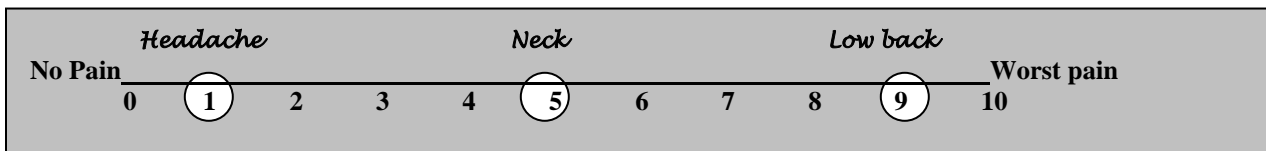
KEY:	
Numbness / Tingling	=====
Pins & Needles	oooooooo
Burning pain	xxxxxxxx
Dull / achy pain
Sharp / Stabbing pain	////////////////



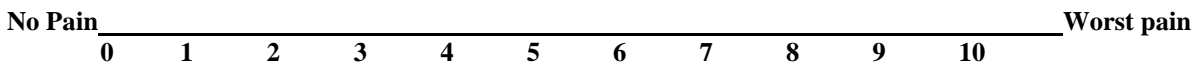
VISUAL PAIN SCALE

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.*

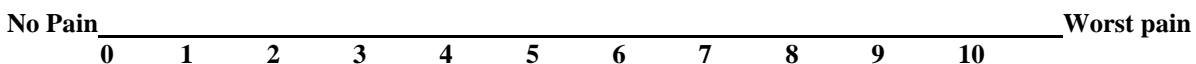
Example:



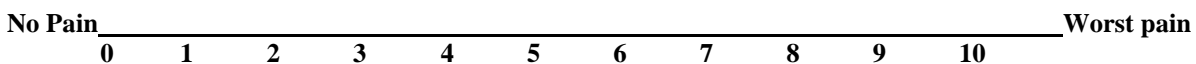
What is your pain RIGHT NOW?



What is your pain at its BEST?



What is your pain at its WORST?



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

ALLERGIC/IMMUNOLOGIC: NONE Food Allergies/sensitivities Seasonal allergies/Hay fever Hives

CARDIOVASCULAR: NONE Ankle swelling Blood clots Chest pain Feeling light headed with standing Heart murmur Heart problems High blood pressure High cholesterol Leg pain with walking short distances Low blood pressure Palpitations (heart skipping beats) Poor circulation Rapid heartbeat Sores that don't heal Varicose veins

CONSTITUTIONAL: NONE Chills Difficulty concentrating Difficulty sleeping Fatigue Fainting Fever Low libido Nervousness Night Sweats Poor appetite Weakness

EARS, NOSE & THROAT: NONE Blisters/cold sores Chronic ear infection Dental problems/toothaches Deviated septum Dry mouth Dysphagia/trouble swallowing Ear noises/ringing Ear pain Gum disease Hearing loss Loss of smell Loss of taste Loss of teeth/ have dentures Motion sickness Nose bleeds Nasal breathing problems Nasal drip Nasal polyps Recurrent ear infections Sinus infections/pain Sore throat/hoarseness Sores/ulcers Tonsillitis Vertigo/dizziness

ENDOCRINE: NONE A loss of appetite Being unusually jumpy or nervous Changes in hair growth or distribution Cold intolerance Excessive hunger Excessive thirst Feeling drowsy after eating Feeling shaky or faint when hungry Heat intolerance Hyperthyroid Hypothyroid Type I diabetes Type II diabetes Unexplained weight gain Unexplained weight loss

EYES: NONE Burning in the eyes Blurred vision Cataracts 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/heart burn Anorexia/Bulimia Constipation Diarrhea Discolored stool Frequent indigestion Gall bladder disease Hemorrhoids Liver disease Nausea Stomach Ulcers Vomiting

GENITOURINARY: NONE A discharge other than urine Bedwetting Bladder control problems Cloudy/foul smelling urine Difficulty starting a stream Discolored urine Dribbling Endometriosis 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 Bruising Dandruff Dryness Eczema Excessive Sweating Nail fungus Plantar warts Psoriasis Rashes Skin cancer Sores

MUSCULOSKELETAL: NONE Arthritis Back injuries Back pain General muscle tension Heel spurs Joint pain Joint stiffness Joint swelling Leg/foot cramps during the day Leg/foot cramps when retiring to bed or at night Muscle cramps Muscle pain Muscle Weakness Neck injuries Neck pain Pain between the shoulders Painful feet Rheumatoid arthritis Scoliosis TMJ pain

NEUROLOGICAL: NONE Confusion Convulsions Difficulty of speech Double vision Epilepsy Fainting spells 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 Considerable emotional stress Crying often Depression Drug addictions/dependency Eating when nervous Extreme worry Feeling angered or irritable Hallucinations Insecurity Nail biting Phobias Recurrent bad dreams Sleep walking Suicidal thoughts

RESPIRATORY: NONE Apnea Asthma Congestion COPD Coughing up blood Difficulty breathing Emphysema Non-productive/dry cough Pneumonia Productive cough Shortness of breath Wheezing

SOCIAL HISTORY: Please answer as completely as possible.

Race: Caucasian African American Asian Indigenous Person Other _____

Ethnicity: Not Hispanic or Latino Hispanic or Latino Other _____

Preferred Language: English Spanish Other _____

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? _____

Cigarette Smoker: Never Current: Amt per day: _____ Former: Quit Date: _____

Smokeless Tobacco/Chew: Never Current: Amt per day: _____ Former: Quit Date: _____

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

First date of last menstrual period (LMP): _____

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.

Environmental: _____

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:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PHARMACY NAME: _____ LOCATION: _____ PHONE #: _____

The 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	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the hip or back at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have dressed/washed more slowly because of my neck pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last few days, my sleeping is moderately disturbed because of neck pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my neck pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

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

Not at all	Slightly	Moderately	Very much	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0	0	1	1

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

The 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	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the shoulder or neck at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have only walked short distances because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my back pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

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

Not at all	Slightly	Moderately	Very much	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0	0	1	1

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