

LAST NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____
 OCCUPATION _____
 EMPLOYER _____
 # OF CHILDREN _____ PHONE _____ CELL _____

FIRST NAME _____ PREFERRED _____
 SS# _____ BIRTHDATE _____ AGE _____
 EMAIL _____
 SPOUSE _____
 SPOUSE'S OCCUPATION _____
 REFERRED BY _____

MY GOAL FOR CONSULTING WITH THE DOCTOR: Temporary Relief Lasting Correction Let Doctor Recommend The Best Type of Care

What is your major complaint? _____

Timing 0-25% 26-50% 51-75% 76-100% of the time

What caused it? How did it start? (Gradual/Injury) _____

Was it related to a work or auto accident? _____

When was the first time you became aware of this problem? How long have you had it? _____

Constant Comes and Goes _____ Is it progressively getting worse? Yes No

Medications you are on now: _____

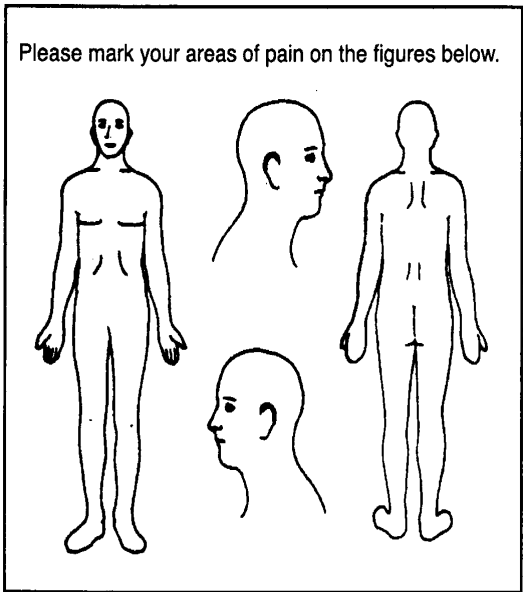
What makes it better? _____ Worse? _____

Describe the problem when it is at its worst? (Check all that apply) Dull Achy Sharp Shooting Refers into my arms

Refers into my legs Other _____

What activity would you like to be able to do again that is difficult or that **YOU CANNOT DO NOW?** _____

This was a new/old illness. What Treatment have you had? _____



Please mark your areas of pain on the figures below.

Mark any other symptoms you have had in the past 6 months.

Rate the severity of your problem: 1-10 (1—slight problem, 10—severe problem) pain.

Leave blank if doesn't apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Numbness - Arms | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Exzema |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Poor Digestion |
| <input type="checkbox"/> Numbness - Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Loss Of Feeling | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Stiff Joints | <input type="checkbox"/> Ear Pain / Noises | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Restricts Daily Activities | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Restricts Regular Exercise | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Elbow | <input type="checkbox"/> High / Low |
| <input type="checkbox"/> Dificulty Speling | <input type="checkbox"/> Headaches | <input type="checkbox"/> Tiredness / Fatigue |
| <input type="checkbox"/> Sore Muscles | | <input type="checkbox"/> Foot Pain |

Surgeries/Hospitalization _____

TRAUMA FROM BIRTH TO PRESENT, PLEASE LIST BY DATE/DESCRIBE

Have you had an MRI/CT Scan? _____ Dates _____

1) Injuries or Falls _____

Previous Chiropractic Care _____

2) Broken Bones _____

Date of last adjustment _____

3) Car/Bike Accidents _____

Female: Are you pregnant at this time? Yes No Due Date _____

Do you have any metal in your body? Yes No

Do you have a pacemaker? Yes No

If yes, where? _____

Primary care physician: _____ Phone number: _____

Physical/Massage Therapist: _____ Phone number: _____

Personal Trainer: _____ Phone number: _____

Signature: _____ Date: _____

Elbow -

- Flex - 160
- Ext. - 0
- Pronation - 90
- Supination - 90

Wrist -

- Flex - 90
- Ext. - 70
- Ulnar Deviation - 65
- Radial Deviation - 20

Doctor's Notes:

Shoulder ROM -

- Flex - 180
- Ext. - 60
- Abd - 150
- Add - 35
- Internal Rotation - 90
- External Rotation - 90

Hip -

- Flex - 125
- Ext. - 15
- Add - 45
- Abd - 45
- External Rotation - 45
- Internal Rotation - 45

Ankle -

- Plantar Flexion - 80
- Dorsiflexion—20

Knee -

- Flexion - 130
- Ext. - 0

Health History of Family Members

The reason for this form is to assist the doctor by providing past health history information for his review

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drinker							
Drug Addiction							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neuritis							
Neuralgia							
Pinched Nerve							
Sinus Trouble							
Smoker							
Sports Activities							
Stomach Trouble							
Deceased							

Name: _____

Date: _____



Case Number _____

Today's Date _____

CA _____ DC _____

1. Accident / Injury Questionnaire

Title: _____ First: _____ MI: _____ Last: _____

Date of accident: _____ Time of accident: _____: _____ am / pm

County in which accident took place: _____ State: _____

What was the cause of your accident / injury: _____

Describe in your own words what happened: _____

2. Immediately After Accident / Injury

Did you lose consciousness? Yes No Unknown

How did you feel (check all that apply):

Confused Dazed Dizzy Nervous Weak Other: _____

Where did you immediately develop PAIN (○) or have lacerations/CUTS (□) (check all that apply):

- | | | | | |
|---|--|---|---|---|
| PAIN CUTS | PAIN CUTS | PAIN CUTS | PAIN CUTS | PAIN CUTS |
| <input type="radio"/> <input type="checkbox"/> Head | <input type="radio"/> <input type="checkbox"/> Neck | <input type="radio"/> <input type="checkbox"/> Upper/Mid Back | <input type="radio"/> <input type="checkbox"/> Lower Back | <input type="radio"/> <input type="checkbox"/> Pelvis |
| <input type="radio"/> <input type="checkbox"/> Abdomen | <input type="radio"/> <input type="checkbox"/> Shoulders | <input type="radio"/> <input type="checkbox"/> Chest/Rib Cage | <input type="radio"/> <input type="checkbox"/> Arms | <input type="radio"/> <input type="checkbox"/> Elbows |
| <input type="radio"/> <input type="checkbox"/> Forearms | <input type="radio"/> <input type="checkbox"/> Wrists | <input type="radio"/> <input type="checkbox"/> Hands | <input type="radio"/> <input type="checkbox"/> Buttocks | <input type="radio"/> <input type="checkbox"/> Hips |
| <input type="radio"/> <input type="checkbox"/> Thighs | <input type="radio"/> <input type="checkbox"/> Knees | <input type="radio"/> <input type="checkbox"/> Legs | <input type="radio"/> <input type="checkbox"/> Ankles | <input type="radio"/> <input type="checkbox"/> Feet |
| <input type="radio"/> <input type="checkbox"/> Other: _____ | | <input type="radio"/> <input type="checkbox"/> Other: _____ | | |

Describe any other significant injury: _____

Did you receive emergency care at the accident/injury site? No Yes—(please check all that apply):

Bandages Splints Brace Neck Collar Other: _____

After the accident/injury, where did you go?

Hospital Home School Work Other: _____

By whom were you driven?

Myself Friend Family Ambulance Other: _____

3. Hospital Visit After Accident / Injury

When did you go to the hospital? Immediately Later That Day Next Day
 Days Later Other: _____ **Never** (skip to section 4 on next page)

Hospital name: _____ Examined by doctor: _____

X-rays were taken of what body part/s:

- | | | | | |
|---------------------------------------|------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Upper/Mid Back | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Shoulders | <input type="checkbox"/> Chest/Rib Cage | <input type="checkbox"/> Arms | <input type="checkbox"/> Elbows |
| <input type="checkbox"/> Forearms | <input type="checkbox"/> Wrists | <input type="checkbox"/> Hands | <input type="checkbox"/> Buttocks | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Thighs | <input type="checkbox"/> Knees | <input type="checkbox"/> Legs | <input type="checkbox"/> Ankles | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Other: _____ | | | | <input type="checkbox"/> No x-rays taken |

A CAT scan was performed on what body part/s:

- | | | | | |
|----------------------------------|---------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Upper/Mid Back | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Chest/Rib Cage |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Other: _____ | | | <input type="checkbox"/> No CAT scan |

A MRI was performed on what body part/s:

- | | | |
|---|-------------------------------|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | given at the hospital (describe location on body): |
| <input type="checkbox"/> Concussion: _____ | | <input type="checkbox"/> Whiplash: _____ |
| <input type="checkbox"/> Disc Injury: _____ | | |
| <input type="checkbox"/> Dislocation: _____ | | |
| <input type="checkbox"/> Fracture: _____ | | |
| <input type="checkbox"/> Sprain: _____ | | |
| <input type="checkbox"/> Strain: _____ | | |
| <input type="checkbox"/> Laceration: _____ | | |
| <input type="checkbox"/> Contusions: _____ | | |

Describe any additional diagnosis given: _____
_____ Upper/Mid Back

- | | |
|--|---|
| Lower Back | <input type="checkbox"/> Chest/Rib Cage |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> No MRI | |

What was the diagnosis _____

What treatment was administered at the hospital?

- | | | | | | |
|--|---------------------------------------|---------------------------------|----------------------------------|--|------------------------------------|
| <input type="checkbox"/> Oral Medication | <input type="checkbox"/> Sutures | <input type="checkbox"/> Splint | <input type="checkbox"/> Collar | <input type="checkbox"/> Injection | <input type="checkbox"/> Ice Packs |
| <input type="checkbox"/> Cast | <input type="checkbox"/> Support | <input type="checkbox"/> Brace | <input type="checkbox"/> Surgery | <input type="checkbox"/> Hot Packs | <input type="checkbox"/> Bandages |
| <input type="checkbox"/> Antiseptics | <input type="checkbox"/> Other: _____ | | | <input type="checkbox"/> No Treatment | |

Upon discharge, whom were you told to see?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Internist | <input type="checkbox"/> General Surgeon | <input type="checkbox"/> Plastic Surgeon |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> No one | |

Upon discharge, what recommendations were made?

- | | | | | | |
|---------------------------------------|------------------------------|-------------------------------|---------------------------------|--|--|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Ice | <input type="checkbox"/> Heat | <input type="checkbox"/> Collar | <input type="checkbox"/> Support | <input type="checkbox"/> Time off work |
| <input type="checkbox"/> Other: _____ | | | | <input type="checkbox"/> No further care | <input type="checkbox"/> No recommendations |

Upon discharge, what medications were prescribed?

- | | | | |
|-------------------------------|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Nervousness |
|-------------------------------|--|--------------------------------------|--------------------------------------|

How much later did additional symptoms develop?

- Immediately
 Hours
 That Evening
 Next Morning
 Days
 Week
 Month
 Other: _____
 No other symptoms

toms

What additional
toms devel-

	Head	Jaw	Neck	Upper	Mid Back	Low Back	Pelvis	Chest/Ribs	Abdomen	Shoulders	Arms	Elbows	Forearms	Wrists	Hands/Fingers	Buttocks	Hips	Thighs	Knees	Legs	Ankles	Feet/Toes	sym- oped?		
(Right)																									
(Left)																									
Pain																									
Burning																									
Numbness																									
Soreness																									
Stiffness																									
Swelling																									
Tingling																									
Weakness																									

Since your accident/injury, have you suffered from:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Vision Trouble | <input type="checkbox"/> Hearing Trouble |
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Breathing Trouble | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Reduced Appetite | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> No additional symptoms | |

Are you restricted in any of the following areas as a result of this accident / injury?

- Daily Living
 Work/Occupational
 Recreational Activities
 Other: _____
 No restrictions

Have you missed work due to this accident / injury?

- Missed no work
 Limited work activity
 Missed work from: _____ to _____

Did you self treat your symptoms?

- Ice Heat Bed rest OTC Medication
 Other: _____ **Did not self treat**

Did you seek health care elsewhere?

- General Practitioner Internist Chiropractor Neurologist
 Orthopedist General Surgeon Plastic Surgeon Psychologist
 Other: _____ Did not seek other health care

Name/s of doctor/s: _____

Diagnosis, treatment and recommendations: _____

Have you had any of the following tests?

- CT Scan MRI EMG Other: _____ No tests

What is the reason for seeking today's consultation?

- Persisting Complaints Worsening of Symptoms Other: _____

Have you contacted an insurance adjuster or representative regarding this claim?

- No Yes—Company: _____ Claim#: _____

Adjuster: _____ Phone: _____

Have you engaged the services of an attorney?

- No Yes—Attorney: _____

Address: _____ Phone: _____

Have you filed an accident / injury report? No Yes

Have you filed for insurance benefits? No Yes

Additional information: _____

I certify that the information provided above is accurate and complete to the best of my knowledge.

Patient Name (Please Print)

Patient Signature

Date Signed

Witness

For office use only: